

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04967

CERTIFICATE OF DEATH

04967

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 15 <u>34 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll County General Hospital</u>		d. STREET ADDRESS <u>4 First Road</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES WILLIAM BANKERT</u>		4. DATE OF DEATH <u>APRIL 7 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 10, 1910</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assistant manager of Soft Drink Bottling Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Union Mills Carroll Co. Md.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Bankert</u>		14. MOTHER'S MAIDEN NAME <u>Myrtle Matsum</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>213-05-1191</u>	
17. INFORMANT <u>Mrs. Madeline C. Bankert</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute peritonitis</u> DUE TO (b) <u>reticulum cell carcinoma</u> DUE TO (c) <u>4-5 days</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>66</u> , to <u>April 7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 7</u> , 19 <u>67</u> , and that death occurred at <u>1:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u>		22b. DATE SIGNED <u>4/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY M.D.</u>		22d. ADDRESS <u>2 Quaker St Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Salisbury, Md.</u>
24. FUNERAL DIRECTOR <u>L. E. Myers, Jr. Westminster, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 11 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04968

CERTIFICATE OF DEATH

04968

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Co. General Hospt.		d. STREET ADDRESS 215 1/2 Main Street	
3. NAME OF DECEASED (Type or print) First Ida Middle Helema Last Belt		4. DATE OF DEATH Month 4 Day 1 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1896
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 4 Days 1 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Carroll Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jonas Lippy		14. MOTHER'S MAIDEN NAME Emily Lowe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-32-5104	
17. INFORMANT Mr. Orion E. Belt		Address Carrollton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RHEUMATIC HEART DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH WEEKS YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PULMONARY EMPHYSEMA			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/25 , 19 67 , to 4/1 , 19 67 , that (I) (we) last saw the deceased alive on 4/1 , 19 67 , and that death occurred at 9:43 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Theresa J. Kocak</i>		22b. DATE SIGNED 4/1/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 5, 1967	23c. NAME OF CEMETERY OR CREMATORY Wesley Cemetery	23d. LOCATION (City or Town) (County) (State) Carroll Co. Md.
24. FUNERAL DIRECTOR Tipton- Eline Funeral Home		25a. REC'D BY REGISTRAR APR 5 1967	
ADDRESS Hampstead, Md.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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88070

IRASO T. JORDON

1913

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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<div> <div>04969</div> <div>04969</div> </div>									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)				
a. COUNTY					a. STATE				
Carroll					Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Westminster					Glyndon Upperco				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				
Carroll County General Hospital					Hanover Road Upperco				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last					Month Day Year				
Rose M. Bianca					April 26, 1967				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Aug. 19, 1881		85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				-		Cefalu, Italy		U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
John Ranzino					Mary Raimondi				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Address		
No					None		Mrs. Jennie M. Bucci Hanover Rd. Upperco, Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									
334X DUE TO Cerebral arteriosclerosis									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
Hour a.m. p.m. 19			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						
21. I certify that (I) (this hospital) attended the deceased from April 21, 1967, to April 26, 1967, that (I) (we) last saw the deceased alive on April 26, 1967, and that death occurred at 9:05 AM, from the causes and on the date stated above.									
22a. SIGNATURE					22b. DATE SIGNED				
John S. Harshey					4/26/67				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
JOHN S. HARSHEY, M.D.					8 Anchar St. Westminster, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		5/1/67		Holy Redeemer Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR ADDRESS					25a. REGISTRAR'S SIGNATURE				
Wm. Cook-Brooks Towson 1050 York Rd. 21204					APR 28 1967 Charles Judge				

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLEBURG</u>		c. LENGTH OF STAY IN lb <u>1 YEAR</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BROOKFIELD MANOR NURSING HOME</u>			d. STREET ADDRESS <u>BARK HILL</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>CHARLES FRANCIS BOWERS</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>16</u> Year <u>19 67</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 13 - 1886</u>		9. AGE (In years last birthday) <u>80</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWNER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>CHARLES W BOWERS</u>		
14. MOTHER'S MAIDEN NAME <u>LAURA L. (UNKNOWN)</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		
16. SOCIAL SECURITY NO. <u>217-36-3945</u>			17. INFORMANT <u>CATHERINE V YOUNG YORK PA.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>4221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>arteriosclerotic C.V.D.</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/7/60</u> , 19 <u>60</u> , to <u>4/16/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/15/67</u> , 19 <u>67</u> , and that death occurred at <u>12:30 PM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>M.E. Robertson</u>			22b. DATE SIGNED <u>4/17/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>ME ROBERTSON</u>			22d. ADDRESS <u>New Windsor, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-19-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>	23d. LOCATION (City or Town)	(County)	(State) <u>MD</u>
24. FUNERAL DIRECTOR <u>DD Hartzler & Sons Union Bridge</u>			25a. REC'D BY REGISTRAR <u>APR 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04971 CERTIFICATE OF DEATH 04971

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>GARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>40 YRS.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>69 PENNA. AVE.</u>		e. STREET ADDRESS <u>69 PENNA. AVE.</u>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>UPTON</u> Last <u>BOWERS</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 17, 1892</u>
9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRESSER, CLOTHING FACTORY</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL CO. MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JAMES BOWERS</u>	
14. MOTHER'S MAIDEN NAME <u>FLORENCE MITTEN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>215-05-61244</u>		17. INFORMANT <u>MRS. MILDRED L. BOWERS</u> Address <u>SAME ADDRESS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1621</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u>Alveolar Adeno-Carcinoma both lungs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio-sclerotic Heart Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 17</u> , 19 <u>65</u> , to <u>4-27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-26</u> , 19 <u>67</u> , and that death occurred at <u>6:30 P.</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>C. K. Billingslea</u>		22b. DATE SIGNED <u>4-28-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. K. Billingslea</u>		22d. ADDRESS <u>Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5/1/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH CEMETERY</u>	23d. LOCATION (City, town or county) (State) <u>WESTMINSTER MD.</u>
24. FUNERAL DIRECTOR <u>J. E. MYNOR, J. WESTMINSTER, MD.</u>		25a. REC'D BY REGISTRAR <u>DAVID</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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04972

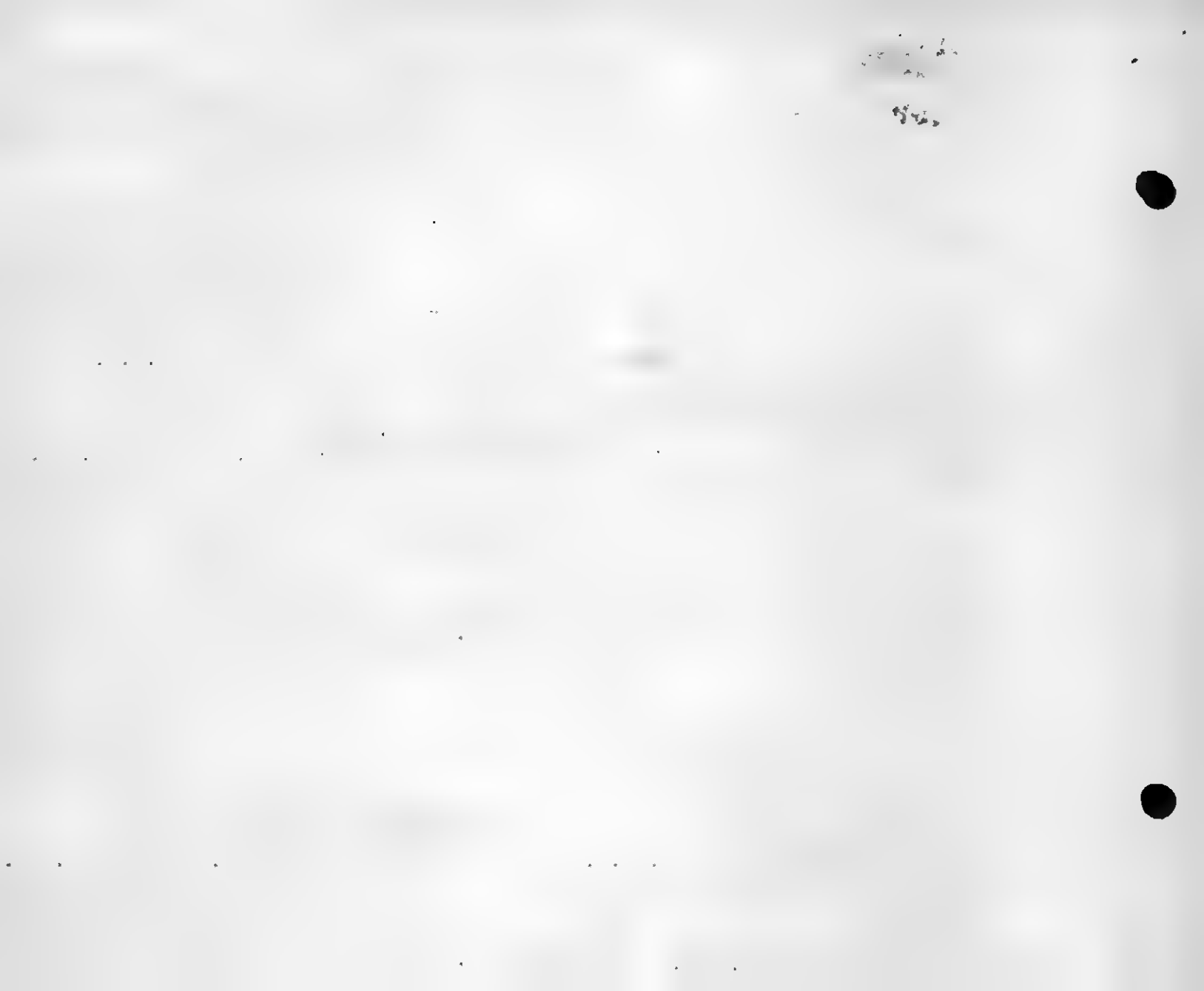
CERTIFICATE OF DEATH

04972

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 38 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 61 E. Randall Street	
3. NAME OF DECEASED (Type or print) Pearl Jacobs Callender		4 DATE OF DEATH Month 4 Day 27 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 03-04-92
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	9 AGE (In years last birthday) 75 yrs
11 BIRTHPLACE (County & State, or foreign country) Maryland, Baltimore		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Morris Jacobs		14 MOTHER'S MAIDEN NAME Mary	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 220-54-6671	
17. INFORMANT Med. Record		Address Springfield Hospital, Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO (b) Metastatic carcinoma of the liver due to DUE TO (c) Old breast cancer			INTERVAL BETWEEN ONSET AND DEATH days years years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic Reaction, Paranoid type.			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 6-25-29 , 19 67 , to 4-27 , 19 67 , that (X) (we) last saw the deceased alive on April 27 , 19 67 , and that death occurred at 11:45 A.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Naci Buyukunsal</i>		22b. DATE SIGNED 4-27-67	
22c. PHYSICIAN'S NAME (Type) Naci Buyukunsal, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4/28/67	23c. NAME OF CEMETERY OR CREMATORY OHEB SHALOM	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.		25a. REC'D BY REGISTRAR MAY 1 1967	
		25b. REGISTRAR'S SIGNATURE <i>O'Brien, Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04973 Item #7 Film 301 471176 04973

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>30 W. Green St.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> d. STREET ADDRESS <u>30 W. Green St.</u>	
3. NAME OF DECEASED (Type or print) <u>ODEN CORTLAND CORBIN</u>		DATE OF DEATH <u>April 4 1967</u>	
5. SEX <u>Male</u>		8. DATE OF BIRTH <u>May 2 1888</u>	
6. COLOR OR RACE <u>White</u>		9. AGE (In years last birthday) <u>78</u> yrs.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (In years last birthday) <u>78</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Md.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Broker</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William L. Corbin</u>		14. MOTHER'S MAIDEN NAME <u>Florence Yingling</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01-0698</u>	
17. INFORMANT <u>John E. Corbin, same address</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> 157X CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Metastases to liver & lung</u> DUE TO (c) <u>Leukemia</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs. 6 months</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-3-1967</u> to <u>4-4-1967</u> , that (I) (we) last saw the deceased alive on <u>4-3-1967</u> and that death occurred at <u>4-4-1967</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>James G. Saffell MD</u>		22b. DATE SIGNED <u>4-6-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James G. Saffell</u>		22d. ADDRESS <u>Main St. Reisterstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 7 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Meadow Branch</u>		23d. LOCATION (City, town or county) (State) <u>Carroll Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Rogers, Jr. Westminster, Md.</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		25c. DATE <u>APR 10 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate must be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

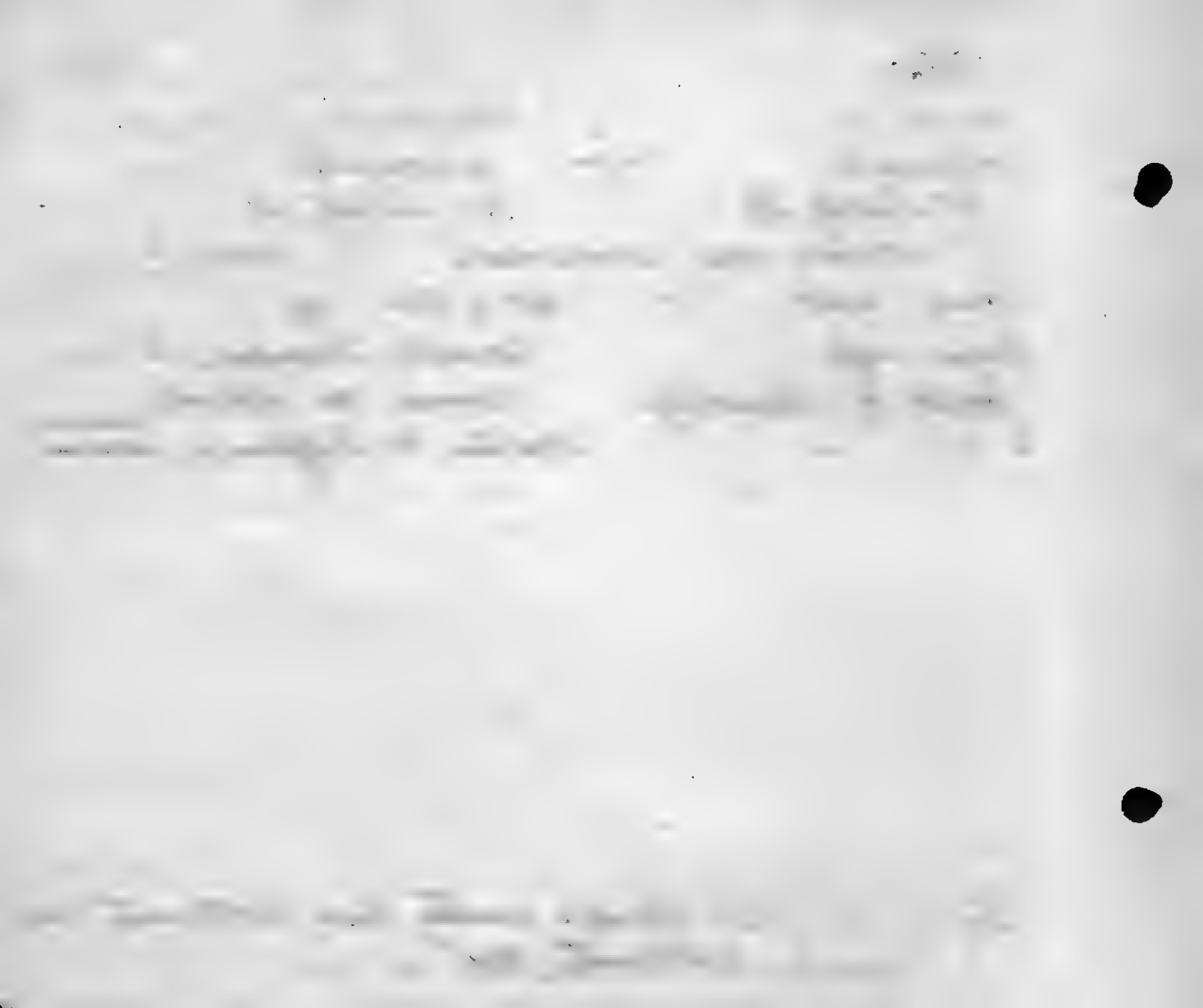
VR A15 (4)
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04974

04974

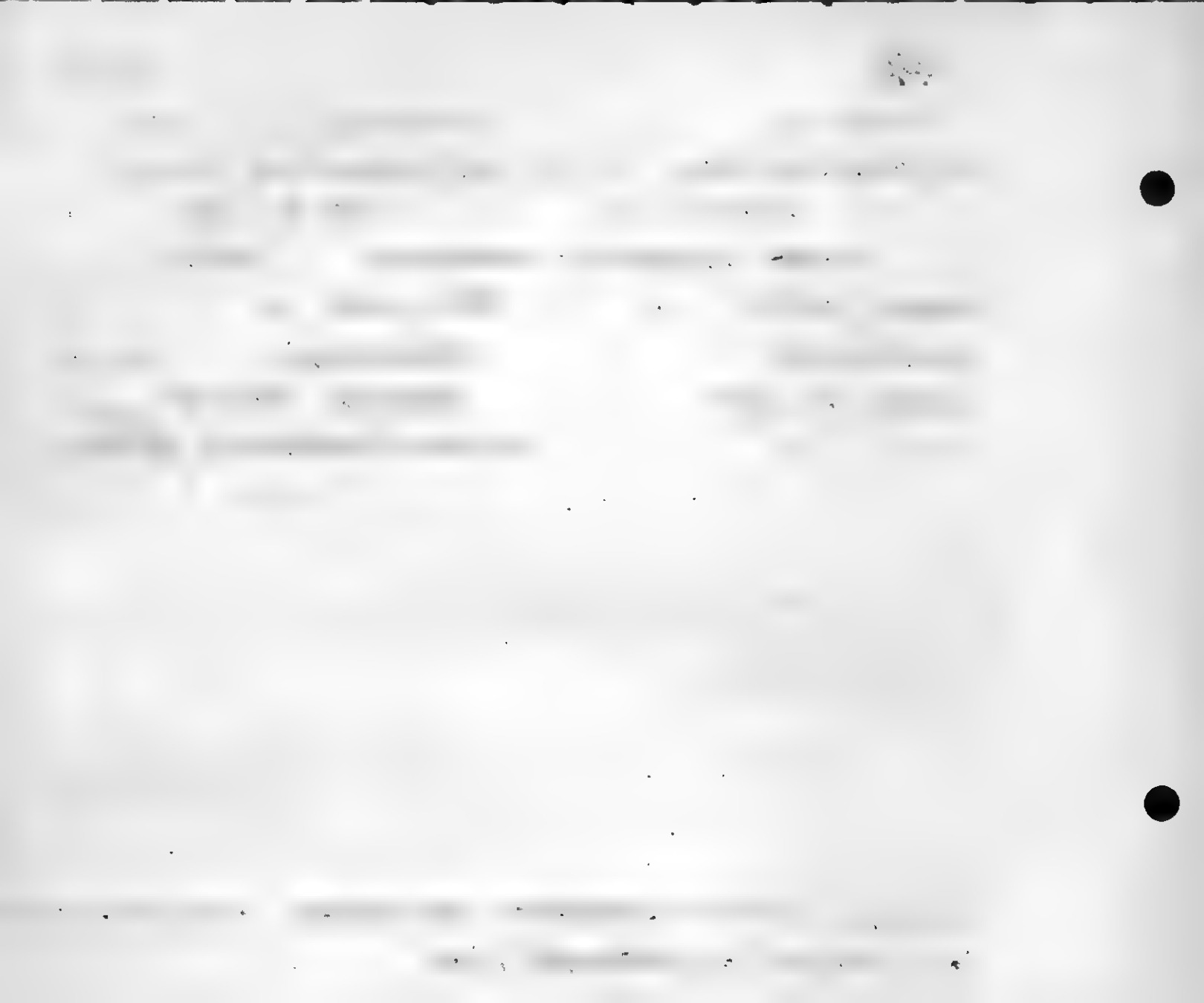
1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN b. <u>84 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>50 Liberty St.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> d. STREET ADDRESS <u>50 Liberty St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JENNIE LOUISE DIFFENDAL</u> First Middle Last		4. DATE OF DEATH <u>APRIL 5 1967</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18 1882</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob H. Handley</u>		14. MOTHER'S MAIDEN NAME <u>Annie M. Warner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>Martin W. Diffendal</u>	
17. INFORMANT <u>Same address</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>(Had Influenza + Pneumonia)</u> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>March 24, 1967</u> to <u>April 4, 1967</u> that (I) (we) last saw the deceased alive on <u>April 4, 1967</u> and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>J. E. Billingslea</u> M.D.		22b. DATE SIGNED <u>APR 7 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. E. Billingslea</u>		22d. ADDRESS <u>Westminster, Maryland</u>	
23a. BURIAL, CREMATION (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/7/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Frederick Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Westminster, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>		25a. REC'D BY REGISTRAR <u>APR 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-chapters. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04975 CERTIFICATE OF DEATH 04975									
1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER RD#4 c. LENGTH OF STAY IN 1b 50 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ROUTE 140					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER, RD#4 d. STREET ADDRESS ROUTE 140				
3. NAME OF DECEASED (Type or print) LAURA BURNETTE DRECHSLER					4. DATE OF DEATH APRIL 20 1967				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 6, 1886		9. AGE (In years last birthday) 81 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN G. ELY					14. MOTHER'S MAIDEN NAME BERTHA BOLTE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -					16. SOCIAL SECURITY NO. -		17. INFORMANT LESTER E. DRECHSLER Address SAME ADDRESS		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Valvular Heart Disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Influenza with Bronchitis									INTERVAL BETWEEN ONSET AND DEATH 10+ yrs
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 1957, 19 to April 19 1967 that (I) (we) last saw the deceased alive on Apr. 19 1967 and that death occurred at 3:30 PM from the causes and on the date stated above.									
22a. SIGNATURE E. Reese Wilkens M.D.					22b. DATE SIGNED 4/20/67				
22c. PHYSICIAN'S NAME (Type) E. REESE WILKENS					22d. ADDRESS Kempen Ave. Westminster Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/22/67		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN MEM. GARDENS			23d. LOCATION (City, town or county) (State) FINKSBURG RD MD		
24. FUNERAL DIRECTOR J. S. Mingo, Jr., Westminster, Md					25a. REC'D BY REGISTRAR APR 24 1967		25b. REGISTRAR'S SIGNATURE J. S. Mingo, Jr.		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04976

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04977
04977
MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence without admission) a. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER, MD.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CARROLL CO. GEN. HOSP				d. STREET ADDRESS 154 PENNA AVE			
3. NAME OF DECEASED (Type or print) First LIEVERE Middle LEWIS Last ESSOM				4. DATE OF DEATH Month APR Day 2 Year 1967			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 14, 1911	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 5 Days 6 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WORKER, MEAT PACKING PLANT				10b. KIND OF BUSINESS OR INDUSTRY WESTMINSTER, MD			
11. BIRTHPLACE (County & State, or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CHARLES WM. ESSOM				14. MOTHER'S MAIDEN NAME FLORENCE LOATS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W.II				16. SOCIAL SECURITY NO. 219-01-4512			
17. INFORMANT MRS FLORENCE L. ESSOM, ADDRESS				Address SAME			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO (b) CORONARY ARTERY DISEASE 1 YEAR DUE TO (c) ARTERIOSCLEROTIC CARDIOVASCULAR DIS 2 YEAR PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from SEPT 1965 to APRIL 1967 , that (I) (we) last saw the deceased alive on APRIL 2 1967 , and that death occurred at 5:15 M. from the causes and on the date stated above.							
22a. SIGNATURE Daniel E Welliver				22b. DATE SIGNED 4-2-67			
22c. PHYSICIAN'S NAME (Type) DANIEL E WELLIVER				22d. ADDRESS 19 RIDGE RD WESTMINSTER			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/15/67			
23c. NAME OF CEMETERY OR CREMATORY KRIDERS CEMETERY				23d. LOCATION (City, town or county) (State) WESTMINSTER MD			
24. FUNERAL DIRECTOR J. E. Myers Jr., Westminster, Md.				25a. REC'D BY REGISTRAR APR 5 1967			
				25b. REGISTRAR'S SIGNATURE J. Charles Judge			

1941

1. The first part of the report is a general
description of the project and its objectives.
2. The second part is a detailed description of the
methodology used in the study.
3. The third part is a description of the results
of the study.
4. The fourth part is a discussion of the results
and their implications.
5. The fifth part is a conclusion and a list of
references.

1. The first part of the report is a general
description of the project and its objectives.
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
15M 7-67

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04978

Item #2d Film #33-4,34,37 cc

CERTIFICATE OF DEATH

04978

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md</u> c. LENGTH OF STAY IN b <u>16.4 hr</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Long View Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md</u> d. STREET ADDRESS <u>126 N. Main Street</u>	
3. NAME OF DECEASED (Type or print) <u>Philip Jacob Flator</u>		4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 9, 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter (postal clerk)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co</u>	
13. FATHER'S NAME <u>Philip Flator</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth White</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>flies give war or dates of service</u>		16. SOCIAL SECURITY NO. <u>212-01-4400</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Card & Vascular Disease</u> DUE TO (b) <u>5 yrs</u> DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>per meoson's Anemia -</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1967</u> to <u>4/1/1967</u> , that (I) (we) last saw the deceased alive on <u>4/1/1967</u> , and that death occurred at <u>6:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W H Foard</u>		22b. DATE SIGNED <u>4/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. H Foard M.D</u>		22d. ADDRESS <u>Manchester, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sandymount Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Sandymount, Carroll Co. Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton - Eline Funeral Home</u>		25a. REC'D BY REGISTRAR <u>APR 5 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

04979

CERTIFICATE OF DEATH

04979

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>Month</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Co. General Hospital</u>		d. STREET ADDRESS <u>R.D. 1</u>	
3 NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>F.</u> Last <u>FLYING</u>		4 DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 6, 1912</u>
9 AGE (in years last birthday) yrs <u>54</u>		10 IF UNDER 1 YEAR Months <u>1</u> Days <u>13</u> Hours <u>19</u> Min <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Baltimore City, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Swiston</u>		14. MOTHER'S MAIDEN NAME <u>Pauline ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>16-03-7766</u>	
17 INFORMANT <u>Mr. Raymond O. Fleming Jane As #2</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>lost</u>		INTERVAL BETWEEN ONSET AND DEATH <u>17 DAYS</u> <u>4 YEARS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/27, 1967</u> to <u>4/13, 1967</u> , that (I) (we) last saw the deceased alive on <u>4/13, 1967</u> , and that death occurred at <u>7:26</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Vincent J. Fiocco</u> M.D.		22b. DATE SIGNED <u>4/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Vincent J. Fiocco</u>		22d. ADDRESS <u>Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4/16/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Morgan Chapel</u>		23d. LOCATION (City or Town) (County) (State) <u>Carroll Co., Md.</u>	
24. FUNERAL DIRECTOR <u>C. M. Woltz</u>		25a. REC'D BY REGISTRAR <u>APR 17 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

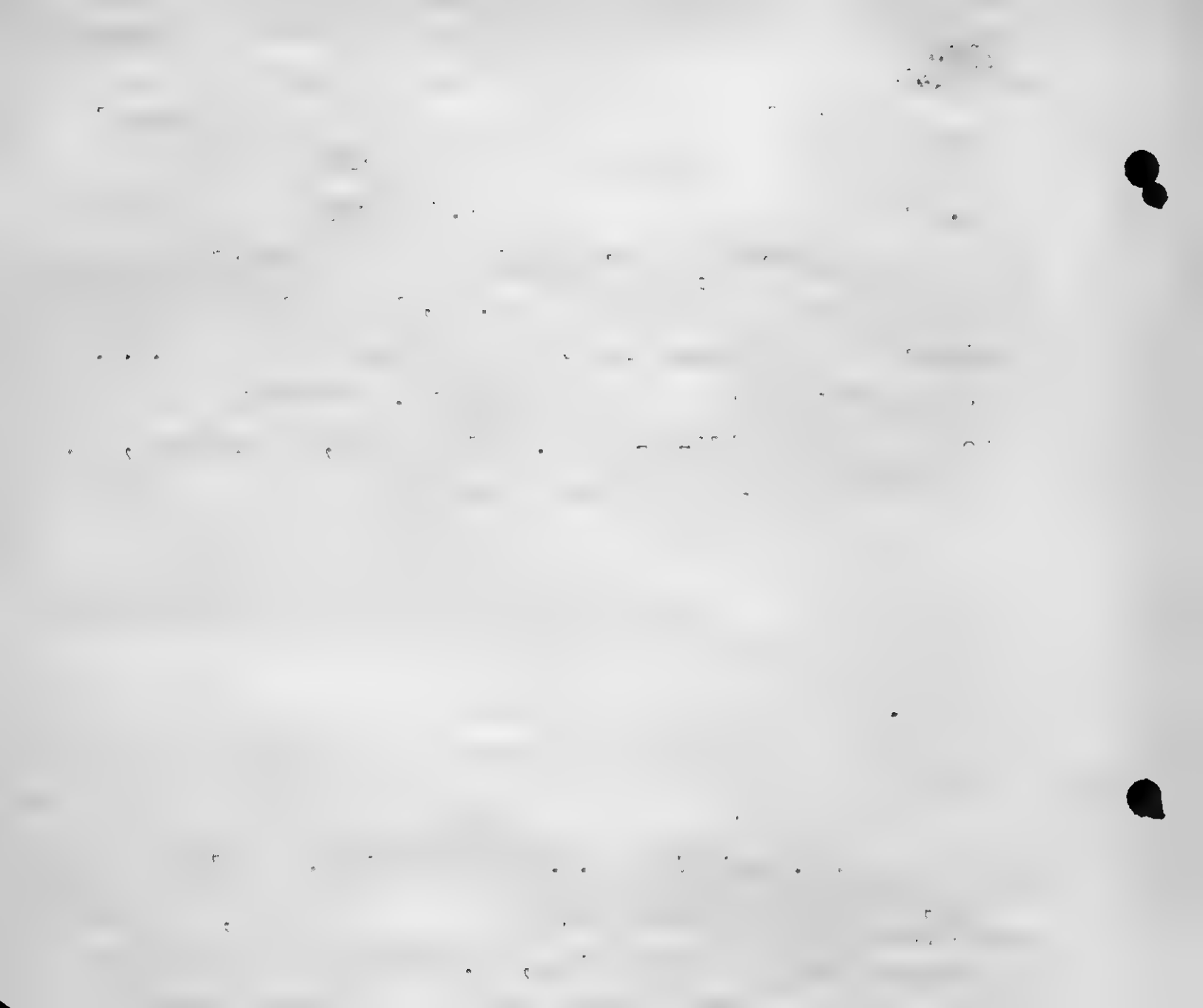
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

04980

04980

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Union Bridge</u> c. LENGTH OF STAY IN 1b <u>years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>E. Broadway</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Union Bridge</u> d. STREET ADDRESS <u>E. Broadway</u>	
3. NAME OF DECEASED (Type or print) <u>Gordon Hunter Fogle</u>		4. DATE OF DEATH <u>April 3, 1967</u>	
5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 16, 1886</u> 9. AGE (In years last birthday) <u>81 yrs.</u> IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Cement Plant</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wesley Fogle</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Flickinger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-03-1095</u> 17. INFORMANT <u>A. Pauline Fogle, Union Bridge, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Atherosclerosis</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> DUE TO <u> </u> (c) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hiatus Hernia, with hemorrhage</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>9/23/64</u> 19 <u> </u> to <u>4/3/67</u> 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>4/1/67</u> 19 <u> </u> , and that death occurred at <u>12 NOON</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>J. H. Caricofe</u>		22b. DATE SIGNED <u>4/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. H. Caricofe</u> M.D.		22d. ADDRESS <u>Union Bridge, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/6/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		23d. LOCATION (City, town or county) <u>Uniontown, Maryland</u> (State) <u> </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>D. H. Hartley & Sons</u>		25a. REC'D BY REGISTRAR <u>APR 5 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

<div> <div>Item 206 Film 389 5-31-67</div> <div> <div>1</div> <div>04981</div> </div> </div> <div> <div> <div>FOR STATE HEALTH DEPT.</div> <div>04981</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>04981</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER c. LENGTH OF STAY IN ID DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA CARROLL CO GENERAL HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE d. STREET ADDRESS 205 MAIN ST e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) RICHARD LEROY FORNEY First Middle Last 4. DATE OF DEATH APRIL - 14 - 1967 Month Day Year						5. SEX M 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH DEC 16 - 1941 9. AGE (In years last birthday) 25 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR 10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA						13. FATHER'S NAME CLAUDE E FORNEY 14. MOTHER'S MAIDEN NAME EDITH REESE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO 16. SOCIAL SECURITY NO. 218-38-3891 17. INFORMANT CELINE FORNEY Address MD UNION BRIDGE						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Cervical Vertebra 824.0 DUE TO Skull injury + multiple Body Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Fractures DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Fell out of truck rounding Curve on Haulp 20c. TIME OF INJURY Month, Day, Year 10:30 PM 4-14-67 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hawkes Hill Rd Union Bridge Carroll Md 20f. (City or town) (County) (State)						21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) W GLENN SPEICHER M.D. 135 E. Preston Street Baltimore Md 22. DATE SIGNED 4-14-67					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 4-17-67 23c. NAME OF CEMETERY OR CREMATORY WINTERS 23d. LOCATION (City, town or county) NEW WINDSOR MD						24. FUNERAL DIRECTOR DW Hartzler & Sons Union Bridge, Md ADDRESS 135 E. Preston Street Baltimore Md 25a. REC'D BY REGISTRAR APR 18 1967 DATE Charles Judge 25b. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain and file with the death certificate. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

04982

CERTIFICATE OF DEATH

04982

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Westminster</u>		c. LENGTH OF STAY IN 1b <u>31 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Westminster</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.D. 6</u>				d. STREET ADDRESS <u>R. D. 6</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MOS R. GARTRELL</u>				4. DATE OF DEATH Month Day Year <u>April 25, 19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18, 1889</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician - C.O. R.R.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Aaron Gartrell</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-12-2665</u>		17. INFORMANT Address <u>Mrs. Orlando Farver R.D. Mt. Airy, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prostatic hypertrophy, Carcinoma</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6 MOS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Coronary occlusion</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>65</u> , to <u>4/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/25</u> , 19 <u>67</u> , and that death occurred at <u>1054</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Julius Chapko</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Julius Chapko</u>				22d. ADDRESS <u>851 W. Green St. Westminster, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/28/1967</u>		23c. NAME OF CEMETERY OR CREMATOR <u>Morgan Chapel</u>		23d. LOCATION (City or Town) (County) (State) <u>Carroll Co., Md.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>C. M. Waltz Box 241 Sykesville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04983

04983

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SYKESVILLE</u>				c. LENGTH OF STAY IN 1b <u>3 MO.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PULLEN NURSING HOME</u>				d. STREET ADDRESS <u>COR. MAIN AND BOND STS.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Haines</u>				4. DATE OF DEATH Month <u>7</u> Day <u>11</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 18 1877</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.		11. IF UNDER 24 HRS Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>CARROLL CO. MD.</u>	
13. FATHER'S NAME <u>JOHN BARNES</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA HOOK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>E. GREEN ST. MRS. S. HERBERT YINGLING WESTMINSTER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Cor. heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerotic C.V. disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 yrs.</u> <u>10 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>—</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1.12</u> 19 <u>67</u> , to <u>4.11</u> 19 <u>67</u> , that I last saw the deceased alive on <u>4.3</u> 19 <u>67</u> , and that death occurred at <u>7:45 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sykesville, MD</u> DATE SIGNED <u>4.11.67</u>							
ACTUAL SIGNATURE <u>Sani Okutman</u> M.D.				PHYSICIAN'S NAME (Type) <u>Sani Okutman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/14/67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. PLEASANT CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>FINKSBURG RD #2 MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr.</u> ADDRESS <u>Westminster, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 17 1967</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04984

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04984

1 PLACE OF DEATH a. COUNTY CARROLL MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Pennsylvania b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINISTER		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shippensburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CARROLL COUNTY GENERAL HOSPITAL			d. STREET ADDRESS 36 West King Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last WAYNE Franklin HAMMOND			4 DATE OF DEATH Month Day Year 4 25 1967		
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 26, 1907	9 AGE (in years lost birthday) yrs 59	f. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Osteopath		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Spring Run, Pa.	
13 FATHER'S NAME Martin Franklin Hammond			12 CITIZEN OF WHAT COUNTRY?		
14 MOTHER'S MAIDEN NAME Mary Ann Wolff					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.		17 INFORMANT Address Mrs. Emma Hammond same address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 4221 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Werner U. Spitz		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 4-25-67	
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 4/29/1967		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery	
23d. LOCATION (City or Town) (County) (State) Shippensburg, Pa.					
24. FUNERAL DIRECTOR Wm. J. Tietman - sons		25a. REC'D BY REGISTRAR APR 27 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04985

CERTIFICATE OF DEATH

04985

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg #2 c. LENGTH OF STAY IN 1b 30 YRS. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kay's Mill Road				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg #2 d. STREET ADDRESS Kay's Mill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EVA MAY HANSEN First Middle Last				4. DATE OF DEATH APRIL 11 1967 Month Day Year			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 21 1891	9. AGE (In years last birthday) 75 yrs.	IF FUNDED 1 YEAR Months Days	IF FUNDED 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harasha Nelson Justice				14. MOTHER'S MAIDEN NAME Carrie E. Hardysheil			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 22-1720772148		17. INFORMANT Howard F. Hansen Address Brookbeck RD #1 Puma			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2-5 MIN 3 MOS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from SEPT 1966 to JAN 11 1967 , that (I) (we) last saw the deceased alive on JAN 11 1967 , and that death occurred at 6:45 M, from the causes and on the date stated above.							
22a. SIGNATURE William J. Stewart				22b. DATE SIGNED 4/11/67			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF April 14/67	23c. NAME OF CEMETERY OR CREMATORY Sandymount Cemetery	23d. LOCATION (City, town or county) (State) Finksburg #1 Maryland				
24. FUNERAL DIRECTOR J. E. Myers, Jr., Westminster, Md.				25a. REC'D BY REGISTRAR APR 13 1967		25b. REGISTRAR'S SIGNATURE J. Charles J. J.	



04986

CERTIFICATE OF DEATH

04986

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>	
c. LENGTH OF STAY IN 1b <u>2 weeks</u>		d. STREET ADDRESS <u>Mineral Hill Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Co. Gen. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Clarence</u> Last <u>Harpine</u>		4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-24-1906</u>
9. AGE (In years last birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		13b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>	
13. FATHER'S NAME <u>Lemuel Harpine</u>		14. MOTHER'S MAIDEN NAME <u>Cynthia Golliday</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Golda Harpine</u>		Address <u>Sykesville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5810</u> DUE TO <u>Carbon monoxide</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic bronchitis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 17</u> , 1967, to <u>April 3</u> , 1967, that (I) (we) last saw the deceased alive on <u>April 3</u> , 1967, and that death occurred at <u>9:15</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u>		22b. DATE SIGNED <u>4/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>		22d. ADDRESS <u>8 Avalon St Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-5-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lake View Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Sykesville Md.</u>
24. FUNERAL DIRECTOR <u>Larry W. Knight</u>		25a. REC'D BY REGISTRAR DATE <u>APR 10 1967</u>	
ADDRESS <u>Sykesville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MANCHESTER RD #1</u> c. LENGTH OF STAY IN ID <u>1 WEEK</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER RD #5</u> d. STREET ADDRESS <u>WESTMINSTER RD #5</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM LESTER HIGGINS</u>		4. DATE OF DEATH Month Day Year <u>4 - 23 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 2 1906</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TIMBER AND LOGGING EMPLOYEE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BURNSVILLE, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MORT HIGGINS</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE RANDOLPH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>410-34-0366</u>	
17. INFORMANT <u>MRS. MAUDE S. HIGGINS, RD #5, MD.</u>		Address <u>WESTMINSTER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis (acute)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Glenn Speicher</u> NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) <u>135 E. Main St. Westminster, Md.</u>	
22. DATE SIGNED <u>4-23-67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/26/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MANCHESTER BAPTIST</u>		23d. LOCATION (City, town or county) (State) <u>MANCHESTER RD #1 MD</u>	
24. FUNERAL DIRECTOR <u>S. S. Thompson, Jr. - Westminster, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 26 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04988 CERTIFICATE OF DEATH 04988

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Carroll	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville	
c. LENGTH OF STAY IN b. 1 Year		d. STREET ADDRESS Main St.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pullen Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Myrtle Middle Virginia Last Hipsley		4. DATE OF DEATH Month April Day 22 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-4-1891
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 7 Days 22 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Condon		14. MOTHER'S MAIDEN NAME Josephine Long	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mr. Willie Hipsley - Sykesville, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Ca of Breast DUE TO Ca of Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ca of Breast DUE TO Ca of Breast (c) Ca of Breast	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus; Arteriosclerotic Cardiovascular		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State) —
21. I certify that (I) (this hospital) attended the deceased from Aug 10, 1947 to APR 22, 1967 , that (I) (we) last saw the deceased alive on APR 21, 1967 , and that death occurred at 10 P M, from the causes and on the date stated above.			
22a. SIGNATURE Sani Okutman		22b. DATE SIGNED 4-25-67	
22c. PHYSICIAN'S NAME (Type) Sani Okutman		22d. ADDRESS Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-27-67	23c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery	23d. LOCATION (City, town or county) (State) Sykesville, Md
24. FUNERAL DIRECTOR Harry W. Haight Sykesville, Md.		25a. REC'D BY REGISTRAR MAY 1 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

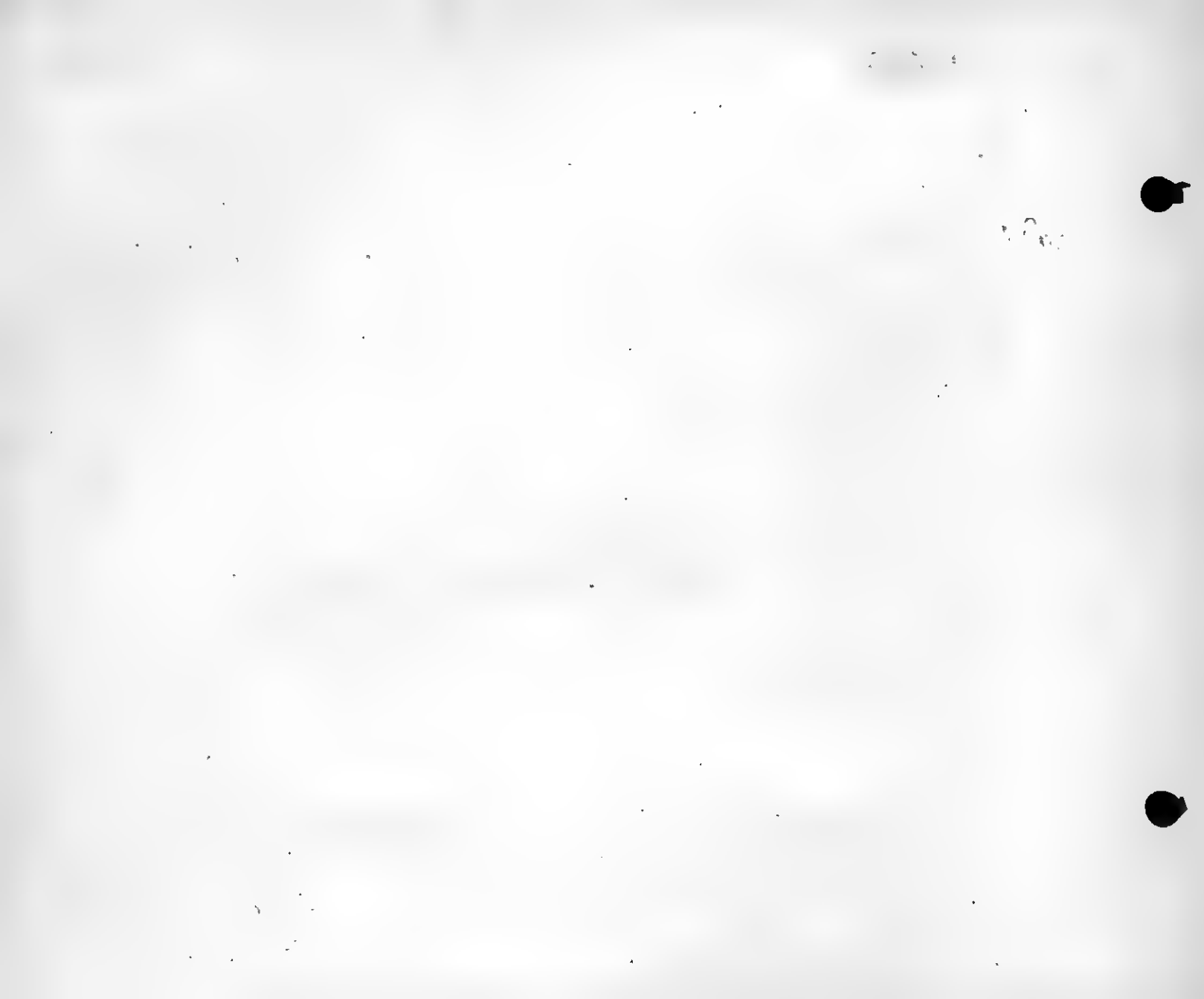
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04989		Item #8 Filed 4/12/67		04989	
1. PLACE OF DEATH a. COUNTY <u>Howard Carroll</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Springfield Ave - Sykesville, Md.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield Ave.</u>			d. STREET ADDRESS <u>Springfield Ave</u>		
3. NAME OF DECEASED (Type or print) First <u>NATHAN</u> Middle <u>C.</u> Last <u>Hobbs, Jr.</u>			4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1967</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1922</u> <u>12-5-1923</u>	9. AGE (In years last birthday) <u>44</u> yrs.	IF UNOER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>Nathan Hobbs, Sr.</u>			14. MOTHER'S MAIDEN NAME <u>Gertrude Shipley</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Mrs. Gertrude Hobbs, Sykesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Influenza</u> DUE TO (b) <u>Myocarditis</u> DUE TO (c) <u>Coronary thrombosis and Cardiac Arrest.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>4/1/67</u> through <u>4/3/67</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 1, 1967</u> , to <u>April 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 3, 1967</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Howard E. Hall</u>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>April 3, 1967</u>
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>			22d. ADDRESS <u>Sykesville, Maryland</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-6-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Springfield Cemetery</u>	
23d. LOCATION (City, town or county)		(State)			
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>		ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 10 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
Item #24, U.C. & d. Form 1034, 4/10/67 pc															
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> c. LENGTH OF STAY IN 1b <u>11/18/67</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Lawrence Junior Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> d. STREET ADDRESS <u>1111 Harrison St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type & print) First Middle Last <u>Jennie M Hortelitter</u>				4. DATE OF DEATH Month Day Year <u>4 2 1967</u>				5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct 19-1889</u> 9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Pa</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles E. Materson</u>				14. MOTHER'S MAIDEN NAME <u>May L. Cheston</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>176-05-2009</u> 17. INFORMANT <u>G.H. Hortelitter</u> Address <u>247 W. Chestnut St</u> <u>Harris Pa</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO <u>Arteriosclerotic Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18] _____															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>White</u> <u>Not White</u> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____															
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 20</u> ..., 19 <u>54</u> to <u>April 2</u> ..., 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 2</u> ..., 19 <u>67</u> , and that death occurred at <u>9:35</u> AM, from the causes and on the date stated above.															
22a. SIGNATURE <u>Joseph E. Bush</u>				22b. DATE SIGNED _____				22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				22d. ADDRESS <u>NAMPCTEAD Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>4/5/67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>St. Ann's</u>				23d. LOCATION (City, town or county) <u>Harris Pa</u> (State) <u>Pa</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jayne V. Kraworth</u>				24b. ADDRESS <u>269 Fredrick St Harris</u>				25. REC'D BY REGISTRAR <u>APR 4 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Jayne V. Kraworth</u>			

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04991

CERTIFICATE OF DEATH

04991

1. PLACE OF DEATH a. COUNTY <u>CARROLL COUNTY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL CO.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>			c. LENGTH OF STAY IN 1b <u>18 HRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MANCHESTER</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL COUNTY GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>RT #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>HAROLD EUGENE JENNINGS</u>				4. DATE OF DEATH Month Day Year <u>APRIL 17 1967</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 21, 1925</u>		
9. AGE (In years last birthday) <u>42</u> yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GENERAL LABORER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>VARIOUS</u>		11. BIRTHPLACE (County & State, or foreign country) <u>SCOTT COUNTY VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CREED J. JENNINGS</u>				14. MOTHER'S MAIDEN NAME <u>MAMIE BOATRIGHT</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES. WWII</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>ROBERT P. JENNINGS</u> <u>BROTHER CATE CITY VA. RT # 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bilateral gastric ulcer</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>36 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>aspirational pneumonia</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (his hospital) attended the deceased from <u>April 16</u> , 1967, to <u>April 17</u> , 1967, that (I) (we) last saw the deceased alive on <u>April 17</u> , 1967, and that death occurred at <u>9:15</u> M, from causes and on the date stated above.								
22a. SIGNATURE <u>Robert F. Bell, M.D.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>April 17, 1967</u>				
22c. PHYSICIAN'S NAME (Type) <u>ROBERT F. BELL MD</u>				22d. ADDRESS <u>187 E. MAIN WESTMINSTER, MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/20/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>JESSEE CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>NICHOLSVILLE SCOTT CO. VA.</u>		
24. FUNERAL DIRECTOR <u>James G. Saffell</u> WESTMINSTER, MD				25a. REC'D BY REGISTRAR <u>APR 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution—residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>		d. STREET ADDRESS <u>RURAL</u>	
3. NAME OF DECEASED (Type or print) First <u>MOSES</u> Middle <u>EUGENE</u> Last <u>JONES</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 25-1918</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BODY WORKS</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>DIRRONDER G. JONES</u>		14. MOTHER'S MAIDEN NAME <u>ANNA MATTHEWS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>231-18-9666</u>	
17. INFORMANT <u>Mrs. MARY K. JONES</u>		Address <u>UNION BRIDGE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO <u>Cardiac Failure - Chronic</u> (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>12/1/56</u> , 19____, to <u>4/11/67</u> , 19____, that I last saw the deceased alive on <u>3/10/67</u> , 19____, and that death occurred at <u>10:50 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>M.E. Robertson</u> M.D. <u>New Windsor, Md.</u> <u>4/11/67</u> PHYSICIAN'S NAME (Type) <u>M.E. ROBERTSON M.D. NEW WINDSOR MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-14-67</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. JAMES CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>NEW WINDSOR MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. HUBBARD</u>		24a. REC'D BY REGISTRAR <u>APR 14 1967</u>	24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the general director, page 3 should be checked far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04993

CERTIFICATE OF DEATH

04993

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Balto.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester md.</i>				c. LENGTH OF STAY IN 1b <i>11 month</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Imperial Nursing Home 128 N. Main St</i>				e. STREET ADDRESS <i>none.</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Lillie May Kemp.</i>				4. DATE OF DEATH Month Day Year <i>4 26 1967</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-5-1877</i>	
9. AGE (In years last birthday) <i>90 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <i>Balto County on farm.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <i>Oliver Cox</i>				14. MOTHER'S MAIDEN NAME <i>Susan Wilhelm</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>217-48-0292</i>		17. INFORMANT <i>Leslie Kempson</i> Address <i>615 Maryland Ave Baltimore Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> 4-26-67 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Arterio-sclerosis & atherosclerosis</i> DUE TO (c) <i>General Arterio Sclerosis.</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 hrs.</i> <i>20 yrs.</i> <i>25 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <i>July 1957</i> to <i>4-26-67</i> , 19 <i>67</i> , that (2) (we) last saw the deceased alive on <i>4-26</i> 19 <i>67</i> , and that death occurred at <i>8:30</i> AM, from the causes and on the date stated above.							
22a. SIGNATURE <i>M.C. Porterfield</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4-26-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>M.C. Porterfield</i>				22d. ADDRESS <i>Hampstead, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4/29/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Forest Baptist Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Upperco, Md.</i>	
24. FUNERAL DIRECTOR <i>Tipton - Eline Funeral Home Hampstead, Md.</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>			
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				DATE <i>MAY 1 1967</i>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

04994

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04994

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			d. STREET ADDRESS 911 N. Carrollton Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JAMES EDWARD KING			4. DATE OF DEATH Month Day Year April 25 19 67		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-9-16		9. AGE (In years last birthday) yrs 50
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rug Cleaner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZENSHIP OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Unknown		
14. MOTHER'S MAIDEN NAME Mary (Maiden name unknown)			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO 248-24-8221			17. INFORMANT Address Records, Springfield State Hospital		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute fatty change of the liver. 5310 DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>William Specker</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 47 25-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/5/67		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery	
23d. LOCATION (City or Town) (County) (State) A A County Md		23e. ADDRESS 1206 W. North Ave		23f. DATE MAY 4 1967	
24. FUNERAL DIRECTOR ADOLPHUS HALSTEAD		24b. ADDRESS 1206 W. North Ave		24c. SIGNATURE <i>Adolphus Halstead</i>	

04995

CERTIFICATE OF DEATH

04995

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 1y. 6d.		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Allegany		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital						d. STREET ADDRESS 548 N. Center St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Clomenzie Clarice		4. DATE OF DEATH April 28 1967		5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 25 1889	
9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Maryland West Virginia		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Benjamin Shuttlesworth		14. MOTHER'S MAIDEN NAME Missouri * Ashby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Springfield Hospital records, Sykesville, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO (b) Terminal bronchopneumonia DUE TO (c) Days		INTERVA. BETWEEN ONSET AND DEATH Days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS											
associated with senile brain disease with psychotic reaction											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (this hospital) attended the deceased from 4/22 , 19 66 , to 4/28 , 19 67 that (we) last saw the deceased alive on 4/28 19 67 , and that death occurred at 10 PM , from causes and on the date stated above.											
22a. SIGNATURE Naci D. Buyukunsal		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Naci Buyukunsal, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 2, 1967		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md					
24. FUNERAL DIRECTOR John J. Havel, Jr.		25a. REC'D BY REGISTRAR DATE MAY 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						04996					
1. PLACE OF DEATH a. COUNTY <u>CARROLL CO</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER RD.</u>				c. LENGTH OF STAY IN ID <u>?</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RD #1</u>				d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DEEP RUN ROAD OFF ROUTE 140</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>ROBERT DAVID LEESE</u>						4. DATE OF DEATH Month <u>APRIL</u> Day <u>22</u> Year <u>1967</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 25 1939</u>		9. AGE (In years last birthday) <u>27</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EMPLOYEE IN GREENHOUSE (FLORIST)</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>CLAYTON J. LEESE</u>						14. MOTHER'S MAIDEN NAME <u>HELEN WEIDNER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>214-36-9641</u>		17. INFORMANT Name <u>DANIEL W. LEESE</u> Address <u>UNION BRIDGE RD #1</u> <u>MARYLAND</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot Left Chest 25 Caliber S&W</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) <u>apparently shot himself in left chest</u> <u>75 Cal Pistol</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>4</u> p.m. <u> </u> 19 <u>67</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, or other place) <u>Home</u>		20f. City or town <u>Westminster</u>		20g. State <u>Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>W. Lewis Peaches</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED <u>4-23-67</u>		
EXAMINER'S NAME (Type) <u>W. Lewis Peaches</u>						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			Address (Street, city, county, and state) <u>135 E. Main St. Westminster Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>4/25/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST DAVIDS CEMETERY</u>			23d. LOCATION (City, town or county) (State) <u>NR. HANOVER PA. ADAMS Co. PA.</u>		
24. FUNERAL DIRECTOR <u>J. E. Myers, Jr. Westminster, Md.</u>						25a. REC'D BY REGISTRAR <u>APR 26 1967</u>			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04997

CERTIFICATE OF DEATH

04997

1 PLACE OF DEATH a COUNTY Carroll MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Md. b COUNTY Carroll			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millers			c LENGTH OF STAY IN 1b 46 years			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millers	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D. 1				d STREET ADDRESS R.D. 1		e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Ida R. Lucabaugh				4 DATE OF DEATH Month April Day 15 Year 1967			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 7, 1878		9 AGE (In years last birthday) yrs 88	IF UNDER 1 YEAR Months 15 Days 19 Hours 67 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Home		11 BIRTHPLACE (County & State, or foreign country) Harford Co. Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Hudson				14. MOTHER'S MAIDEN NAME Annia C. Peregory			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-38-8397		17. INFORMANT Address Mrs. Corinne Tracey Millers, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Certain Schism C-r. Disease DUE TO Dementia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dementia DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1960 25 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (1) (this hospital) attended the deceased from 9m. 19 60 to 4-15-67 , that (1) (we) last saw the deceased alive on 4-12-1967 , and that death occurred at 12:50 AM , from causes and on the date stated above.							
22a SIGNATURE Maurice C. Porterfield M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 4-17-67	
22c. PHYSICIAN'S NAME (Type) Maurice C. Porterfield				22d ADDRESS Hampstead, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 4/18/67		23c NAME OF CEMETERY OR CREMATORY Steltz Union Cem.		23d LOCATION (City or Town) (County) (State) New Freedom Pa.	
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md.				25a REC'D BY REGISTRAR DATE APR 18 1967		25b REGISTRAR'S SIGNATURE William Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04998

CERTIFICATE OF DEATH

04998

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster c. LENGTH OF STAY IN 1b 50 YRS. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 143 E. Green Street				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster d. STREET ADDRESS 143 E. Green St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MAUD Middle ESTELLE Last MANAHAN				4. DATE OF DEATH Month April Day 10 Year 1967			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 27, 1888		9. AGE (In years last birthday) 78 yrs. IF UNDER 1 YEAR: Months 7 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nurse		10b. KIND OF BUSINESS OR INDUSTRY County Health Dept Carroll County		11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles F. Manahan				14. MOTHER'S MAIDEN NAME Ada Nicodemus			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. (If yes give war or dates of service) 219-36-1867		17. INFORMANT Miss Martha E. Manahan		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF COLON WITH METASTASES DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 8, 1966 , to April 10, 1967 , that (I) (we) last saw the deceased alive on April 9, 1967 , and that death occurred at 3:00 PM , from the causes and on the date stated above.							
22a. SIGNATURE William J. Stewart,				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/10/67	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 12/67		23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		23d. LOCATION (City, town or county) (State) Westminster, Maryland	
24. FUNERAL DIRECTOR J. E. Myers, Jr., Westminster, Md.				25a. REC'D BY REGISTRAR APR 13 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

04999

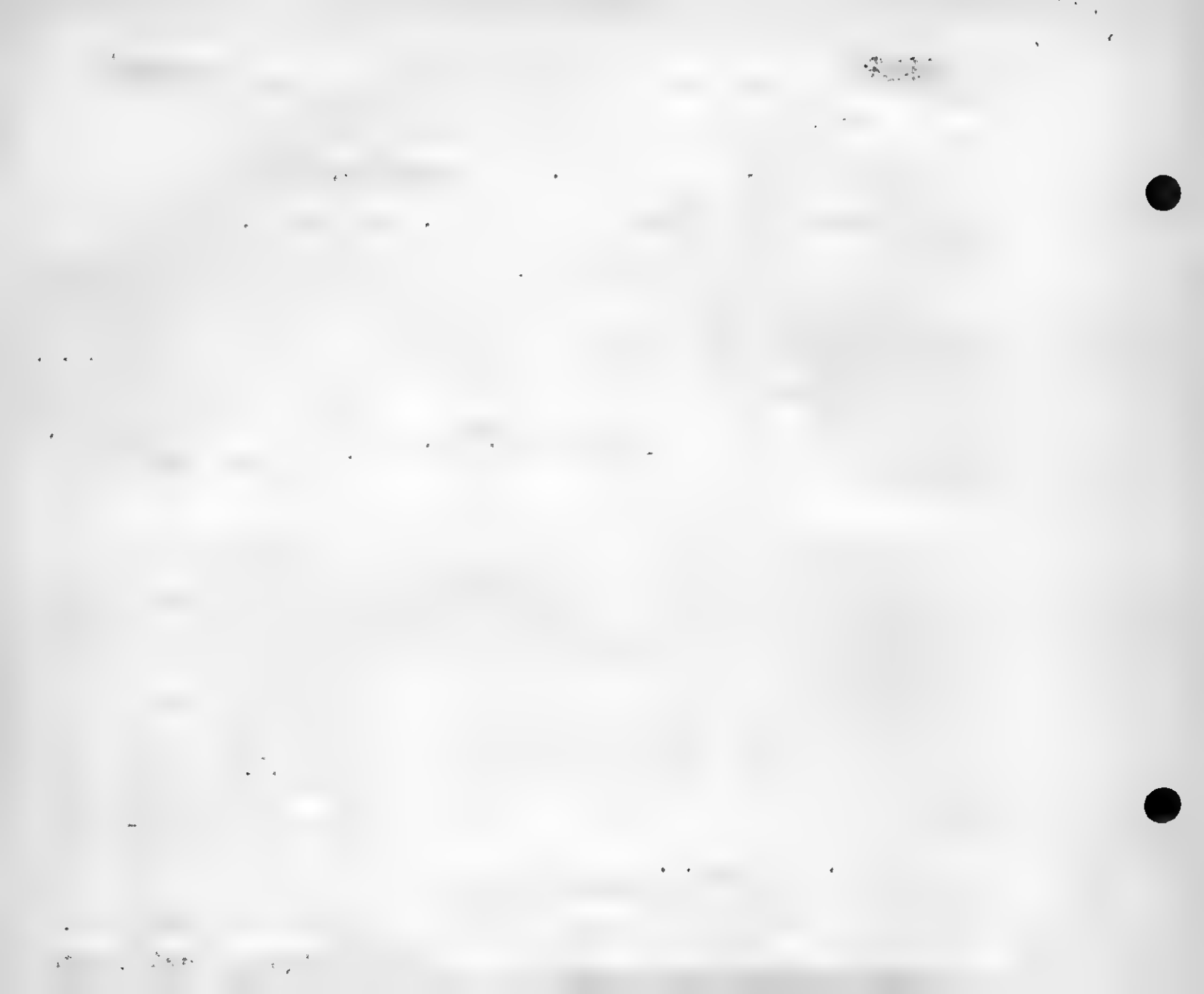
CERTIFICATE OF DEATH

04999

1. PLACE OF DEATH a. COUNTY Carroll County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eggsdale, Md.		c. LENGTH OF STAY IN 1b 10 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. STREET ADDRESS 1 E. Baltimore St.	
3. NAME OF DECEASED (Type or print) Eva Mae Jones May		4. DATE OF DEATH Month April Day 20 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-31-85 87
9. AGE (In years (last birthday)) 79 8 1/2 yrs		10. IF UNDER 1 YEAR Months 8 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Layman Jones		14. MOTHER'S MAIDEN NAME Rachel Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 219-20-4359	
17. INFORMANT Med Rec		Address Sykesville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4 Arteriosclerotic cardiovascular disease DUE TO (b) years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Terminal pneumonia DUE TO (c) weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome, associated with senile brain disease with psychotic reaction			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part of item 18) psychotic reaction	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. INJURY OCCURRED 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20d. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6-15 , 19 66 , to 4-19 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4-19 , 19 67 , and that death occurred at 3:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE R. Espina, M.D.		22b. DATE SIGNED 4-19-67	
22c. PHYSICIAN'S NAME (Type) R. Espina, M.D.		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/24/67	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. CO. MD.	
24. FUNERAL DIRECTOR Louise Funeral Home		25a. REC'D BY REGISTRAR APR 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05000

CERTIFICATE OF DEATH

05000

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 7yrs. 10mos. 21dys.		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital						e. STREET ADDRESS 3435 Roland Ave.			f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First SARAH		Middle EDITH		Last MAYS		4. DATE OF DEATH APRIL Month MARCH Day 12 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-10-1882		9. AGE (in years last birthday) 84 yrs		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		11. IF UNDER 24 HRS Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Bennett Hoshall						14. MOTHER'S MAIDEN NAME Elizabeth Gore					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO 218-09-9789		17. INFORMANT Records, Springfield State Hospital						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 4.201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary arteriosclerosis DUE TO (c) Arteriosclerotic cardiovascular disease										INTERVAL BETWEEN ONSET AND DEATH Hours Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychotic depressive reaction.											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 5-21-59 , 19 to 4-12-67 , 19, that (I) (we) last saw the deceased alive on 4-12-67 , 19, and that death occurred at 11:50 AM from causes and on the date stated above.											
22a. SIGNATURE Agustin del Campo						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4-12-67			
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M. D.						22d. ADDRESS Springfield State Hospital Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/15/67		23c. NAME OF CEMETERY OR CREMATORY Middletown Baptist Cem.		23d. LOCATION (City or Town) (County) (State) Middletown, Md.					
24. FUNERAL DIRECTOR Tipton- Eline Funeral Home Hampstead, Md.						25a. REC'D BY REGISTRAR APR 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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05001

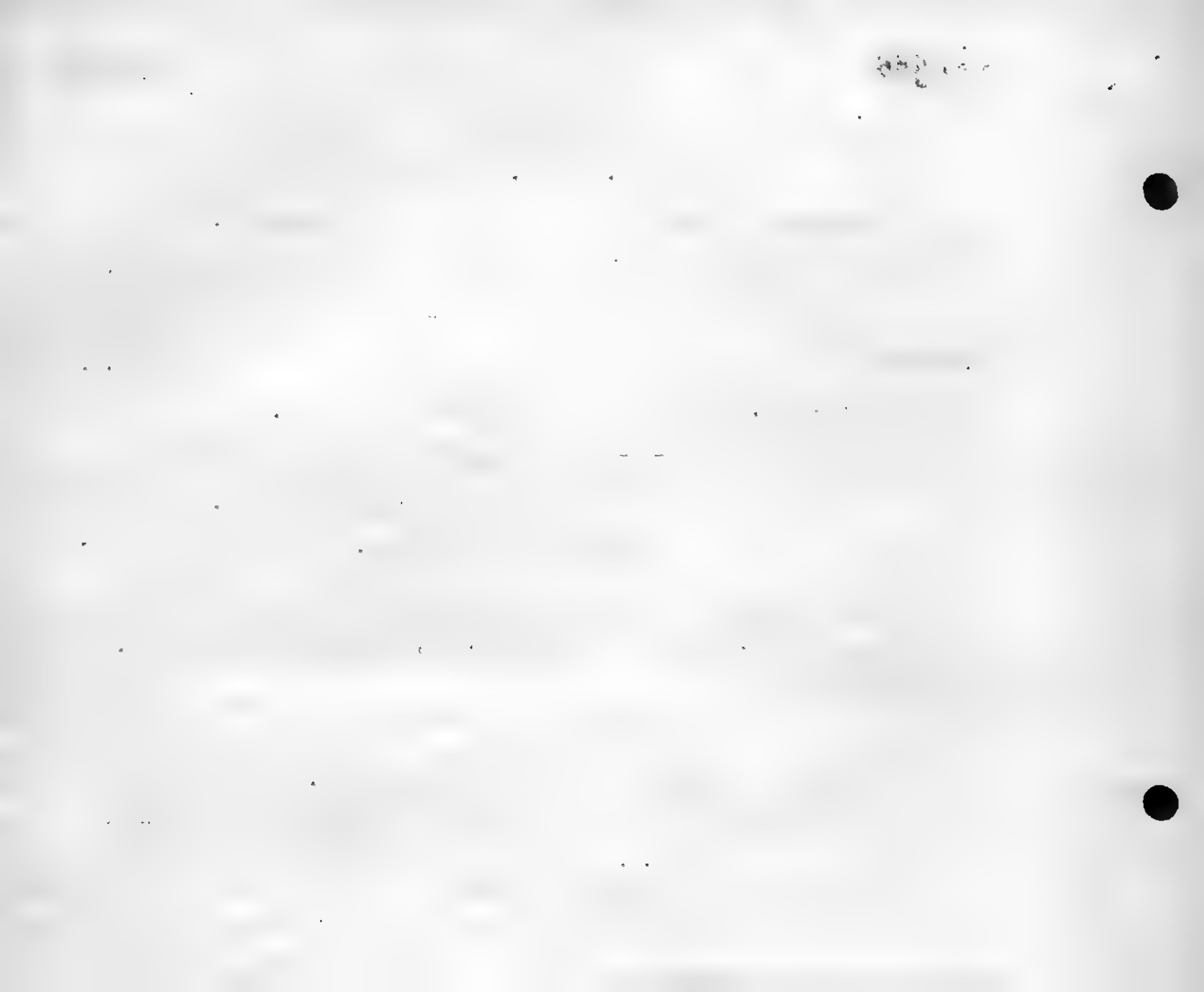
CERTIFICATE OF DEATH

05001

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1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 1 mo. 13 das.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 3905 Edgewood Rd. Apt. 131	
3. NAME OF DECEASED (Type or print) First Harry Middle NMN Last MEYERS		4. DATE OF DEATH Month April Day 16 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-4-04
9. AGE (n years last birthday) 63 yrs		10. IF UNDER 1 YEAR Months 16 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate		10b. KIND OF BUSINESS OR INDUSTRY Bondsman	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Meyer Meyers - dec.		14. MOTHER'S M.A.DEN NAME Sara ? - dec.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 219-32-2028	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arteriosclerotic cardio-vascular disease. DUE TO (b) Generalized arteriosclerosis. DUE TO (c) Diabetes Mellites. CBS, circulatory disorder, with psychotic reaction.			INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellites. CBS, circulatory disorder, with psychotic reaction.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-3-67 , 19__, to 4-16-67 , 19__, that (I) (we) last saw the deceased alive on 4-16-67 , 19__, and that death occurred at 11 a.m. from causes and on the date stated above.			
22a. SIGNATURE Octavio Ruiz		22b. DATE SIGNED 4-16-67	
22c. PHYSICIAN'S NAME (Type) Octavio Ruiz, M.D.		22d. ADDRESS Springfield State Hospital, Sykesville, Maryland 21784	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/18/67	23c. NAME OF CEMETERY OR CREMATORY New Har Sinai	23d. LOCATION (City or Town) (County) (State) Garrison Maryland
24. FUNERAL DIRECTOR Lot. Levinson		25a. REC'D BY REGISTRAR Balt. M.D.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE APR 21 1967	



05002

CERTIFICATE OF DEATH

05002

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1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville c. LENGTH OF STAY IN 1b 13y. 7m. 26d. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution on: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City d. STREET ADDRESS 918 E. Chase St. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Anna Belle Montgomery		4. DATE OF DEATH Month Day Year April 29 1967	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 13, 1891
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mother's helper		10b. KIND OF BUSINESS OR INDUSTRY **	
11. BIRTHPLACE (County & State, or foreign country) unknown		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Heroy Montgomery		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220-54-6601	
17. INFORMANT Springfield Hospital records, Sykesville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carotid fracture 2870 DUE TO (b) Secondary Emphysema due to Montanopneumonia yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS associated with disturbance of metabolism, growth or nutrition with senile brain disease, with psychotic reaction 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Sept. 23, 1953 to Apr. 29, 1967 that (X) (we) last saw the deceased alive on Apr. 29, 1967 , and that death occurred at 9 A.M. from causes and on the date stated above.			
22a. SIGNATURE Dr. Naci Buyukunsal		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Naci Buyukunsal, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 5/3/67		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Johns Hopkins School of Med. 709 N. Wolfe St.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Newell Funeral Home Pikesville - 8 M.		25a. REC'D BY REGISTRAR MAY 4 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
05003						05003						
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)						
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY			
Carroll			Rural-Sykesville			Maryland			Carroll			
c. LENGTH OF STAY IN 1D			d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS			
6 Years			R. D. 2 Box 232			Rural-Sykesville			R. D. 2 Box 232			
e. IS RESIDENCE ON A FARM?			f. NAME OF DECEASED			4. DATE OF DEATH			g. AGE (In years last birthday)			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			First Middle Last			Month Day Year			Years Months Days Hours Min.			
			Murriel C. Morrison			April 19, 1967			54			
5. SEX			6. COLOR OR RACE			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH			
Female			White			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			March 5, 1913			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			
Inn owner & operator									Baltimore Co., Md.			
13. FATHER'S NAME						12. CITIZEN OF WHAT COUNTRY?						
Frank C. Crooks						U.S.A.						
14. MOTHER'S MAIDEN NAME						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						
Mary V. Dorsey						No						
16. SOCIAL SECURITY NO.						17. INFORMANT						
216-05-8849						Mr. Guy W. Morrison Same As #2						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of cervix with extended metastasis											12/66	
171X DUE TO Post radiation, intestinal obstruction											through	
DUE TO Cardiac failure and cardiac arrest.											4/19/67	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											19. WAS AUTOPSY PERFORMED?	
											YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year						20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
Hour a.m. p.m. 19						While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						
21. I certify that (I) (this hospital) attended the deceased from Dec. 1966, to 4/19/67, 1967, that (I) (we) last saw the deceased alive on April 19, 1967 and that death occurred at 4:30, from the causes and on the date stated above.												
22a. SIGNATURE						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
Howard E. Hall											April 20, 1967	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS						
Howard E. Hall, M.D.						Sykesville, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
Burial			4/22/1967			Lakeview Memorial Gardens			Carroll Co., Md.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE
C. M. Waltz Box 241 Sykesville, Md.						APR 24 1967						Charles J. Jones

MEDICAL CERTIFICATION

101



05004

CERTIFICATE OF DEATH

05004

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b part of 1 day		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Westminster	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) RUFUS WILLIAM NORWOOD		4. DATE OF DEATH Month April Day 10 Year 1967			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1880		9. AGE (In years last birthday) yrs 86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Ridgeville, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME William T. Norwood			14. MOTHER'S MAIDEN NAME Lucy Sellman		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 212-24-6051A		17. INFORMANT Earl E. Norwood Address 6 Norva Avenue Frederick, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerotic Heart Disease congestive heart failure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart Disease congestive heart failure					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from April 10, 1967 , to April 10, 1967 , that (I) (we) last saw the deceased alive on April 10, 1967 , and that death occurred at 4:15 P.M. from causes and on the date stated above.					
22a. SIGNATURE John S. Harshey		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/10/67	
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.		22d. ADDRESS Green St Westminster, Md			
23a. BURIAL, CREMATION, REMOVA (Specify) burial		23b. DATE THEREOF April 13/67		23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery	
23d. LOCATION (City or Town) (County) (State) Mt. Airy, Maryland					
24. FUNERAL DIRECTOR J. E. Myers Jr., Westminster, Md.		ADDRESS		25a. REC'D BY REGISTRAR AMR 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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100



05005

CERTIFICATE OF DEATH

05005

1 PLACE OF DEATH a. COUNTY Carroll, Maryland MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on- Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville		c. LENGTH OF STAY IN 1b 10y. 7m. 26d	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 229 E. 32nd. Street	
3. NAME OF DECEASED (Type or print) Charles William O'Neill		4. DATE OF DEATH Month 4 Day 10 Year 1967	
5 SEX male	6. COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-23-90
9 AGE (n years last birthday) yrs. 76		IF UNDER 1 YEAR Months 4 Days 10 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Pilot		10b. KIND OF BUSINESS OR INDUSTRY Bay Pilot on ships	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John R. O'Neill		14. MOTHER'S MAIDEN NAME Margaret Lastner	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO. 218-32-3886	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emphysema DUE TO (b) Chronic Bronchitis DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 yrs. years years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with psychotic reaction, generalized arteriosclerosis		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --	
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --		20f. (City or town) (County) (State) --	
21. I certify that (a) (this hospital) attended the deceased from 8-14 , 1967 , to 4-10 , 1967 , that (b) (we) last saw the deceased alive on 4-10 , 1967 , and that death occurred at 11:50 a.m. from causes and on the date stated above.			
22a. SIGNATURE Mario E. Comas M.D.		22b. DATE SIGNED 4-10-67	
22c. PHYSICIAN'S NAME (Type) Mario E. Comas, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Apr. 13, 1967	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24 FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204		25a. REC'D BY REGISTRAR APR 12 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 4yrs.2mos. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 579 Laurens St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) HATTIE SYLVIA PARKER			4. DATE OF DEATH APRIL 20 19 67						
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-7-1889		9. AGE (In years last birthday) 78 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Myers					14. MOTHER'S MAIDEN NAME Bertha Wilson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Records, Springfield State Hospital			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4221 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with cerebral arteriosclerosis, with psychotic reaction									INTERVAL BETWEEN ONSET AND DEATH years
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>W. Glenn Speicher</i>					22. DATE SIGNED 4-20-67				
EXAMINER'S NAME (Type) W. Glenn Speicher, M. D.					23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town or County, State) <i>635 E. Main St. Baltimore, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/26/1967		23c. NAME OF CEMETERY OR CREMATORY Berkley Cemetery		23d. LOCATION (City, town or county) (State) Washington, Maryland			
24. FUNERAL DIRECTOR <i>Elmer E. Bulluck</i>					25a. REC'D BY REGISTRAR <i>Harold De Groot, Jr.</i> DATE APR 27 1967				
					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

05007

CERTIFICATE OF DEATH

Reg. Dist. No. 05007

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg		c. LENGTH OF STAY IN 1b 7 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williams Nursing Home		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Rebecca Middle May Last Parks		4. DATE OF DEATH Month April Day 11 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 5, 1877
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Butler, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John G. Gill		14. MOTHER'S MAIDEN NAME Mary Hyde	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 215-54-0020	
17. INFORMANT Mrs. Eliz. Warehime- 103 Butler Rd., Reisterstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 7 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-27-69 , 19____, to 4-11-67 , 19____, that I last saw the deceased alive on April 10 , 19 67 , and that death occurred at 2:15P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. Reisterstown, Md. DATE SIGNED 4-12-67			
ACTUAL SIGNATURE D. D. Caples		M.D. 6 Hanover Rd. Reisterstown, Md.	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-14-67	22c. NAME OF CEMETERY OR CREMATORY Jessop	22d. LOCATION (City, town, or county) (State) Cockeysville, Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE D. D. Caples		ADDRESS New Windsor, Md.	
24a. REC'D BY REGISTRAR DATE APR 14 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05008

CERTIFICATE OF DEATH

05008

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> c. LENGTH OF STAY IN 1b <u>7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eline Funeral Home Inc.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u> d. STREET ADDRESS <u>117 Carroll St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harry</u> First Middle Last 4. DATE OF DEATH <u>4</u> <u>17</u> <u>1967</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>7/23/82</u> 9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lock Installer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William L. Pletzer</u> 14. MOTHER'S MAIDEN NAME <u>Laura Kelly</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>213-05-5358</u> 17. INFORMANT <u>Mrs. Arthur C. Bowman</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerosis C-v. Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Pulmonary Embolism; Cholelithiasis</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>3</u> <u>25</u> <u>1967</u> , to <u>4</u> <u>17</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>4</u> <u>17</u> <u>1967</u> , and that death occurred at <u>7:10 PM</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>M. C. Porterfield</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>4-17-67</u> 22c. PHYSICIAN'S NAME (Type) <u>Hampstead Md</u> 22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/20/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Memorial Gardens</u> 23d. LOCATION (City, town or county) (State) <u>Finksburg Carroll Co. Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton - Eline Funeral Home Hampstead, Md.</u> ADDRESS 25a. REC'D BY REGISTRAR <u>APR 20 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

05009

CERTIFICATE OF DEATH

05009

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hosp.</u>		d. STREET ADDRESS <u>2304 Madison Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Georgiana Tankard Revelle</u>		4. DATE OF DEATH <u>4-23-67</u> 19 <u>67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-20-82</u> 19 <u>82</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Emanuel Tankard</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Springfield Hosp. records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4-23-67</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-28</u> , 19 <u>67</u> , to <u>4-23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-23</u> 19 <u>67</u> , and that death occurred at <u>11:30 A.M.</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Orlando C. Rayos</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Orlando C. Rayos</u>		22d. ADDRESS <u>Springfield State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-26-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Exmore Baltimore, Va.</u>	
24. FUNERAL DIRECTOR <u>Edgar K. Wharton</u>		25a. REC'D BY REGISTRAR <u>APR 24 1967</u>	
ADDRESS <u>new church Va.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-13. Page 5 may be retained for your files.

TO MEDICAL EXAMINER: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital					d. STREET ADDRESS Route # 1M			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EARL Middle David Last ROOP		4. DATE OF DEATH Month 4 - Day 9 Year 1967		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 9/18/1903		9. AGE (In years last birthday) 63 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Carroll Co., Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George W. Roop		14. MOTHER'S MAIDEN NAME Berta Nogle		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-36-1146			
17. INFORMANT Mrs. Mary Agnes Roop, R# 1M, Taneytown, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis (acute) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary disease (c) Coronary disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED 4-9-67		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/12/1967		23c. NAME OF CEMETERY OR CREMATORY Keysville Union Cemetery		23d. LOCATION (City, town or county) (State) Keysville, Maryland			
24. FUNERAL DIRECTOR John M. Skiles		25a. REC'D BY REGISTRAR APR 11 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge		25c. CHIEF MEDICAL EXAMINER W. Glenn Speicher		25d. ASSISTANT MEDICAL EXAMINER 135 E. Main St., Westminster, Md.			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05011

05011

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLEBURG</u> c. LENGTH OF STAY IN <u>3 MONTHS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BROOKFIELD MANOR NURSING HOME</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u> d. STREET ADDRESS <u>BARK HILL</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>MARY JANE ROWE</u>		4. DATE OF DEATH <u>APRIL 29 1967</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 27-1880</u>		9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OPERATOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NURSING HOME</u>				11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>ISAAC WELTY</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE FOX</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>218-32-4121</u>		17. INFORMANT <u>MRS HARRY CARR</u> Address <u>UNION BRIDGE MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized atherosclerosis</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive cardiovascular disease</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. TIME OF INJURY Hour <u>19</u> e.m. p.m.		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town)		20e. (County)		20f. (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>1/17/67</u> to <u>4/29/67</u> , that (I) (we) last saw the deceased alive on <u>4/29/67</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.															
22a. SIGNATURE <u>JH Caricofe</u> M.D.				22b. ADDRESS <u>UNION BRIDGE MD</u>				22c. PHYSICIAN'S NAME (Type) <u>JH CARICOFE</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 2-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHURCH OF GOD</u>				23d. LOCATION (City, town or county) <u>UNION TOWN MD</u>		23e. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Old Hartzler & Sons Union Bridge MD</u>				25a. REC'D BY REGISTRAR <u>MAY 2 1967</u>				25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>							

05012

CERTIFICATE OF DEATH

05012

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN TOWN <u>6 mo's. 39 days</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Finksburg, Route #2</u>	
3. NAME OF DECEASED (Type or print) <u>Jarrett Wesley Shauck</u> First Middle Last 4. DATE OF DEATH <u>April 30 1967</u> Month Day Year		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. SEX <u>Male</u>	7. COLOR OR RACE <u>White</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH <u>7-20-91</u> 10. AGE (in years last birthday) <u>75</u> yrs.
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Shauck</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Barber</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-32-2664-A</u>	
17. INFORMANT <u>Records, Springfield State Hospital</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/11/66</u> , 19__, to <u>4/30/67</u> , 19__, that (I) (we) last saw the deceased alive on <u>4/30</u> , 1967, and that death occurred at <u>9:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>H.E. Connor Jr.</u>		22b. DATE SIGNED <u>4/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H.E. Connor Jr. MD</u>		22d. ADDRESS <u>Springfield State Hospital Sykesville, Maryland 21784</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Dumfries, Carroll Co. Md.</u>
24. FUNERAL DIRECTOR <u>J. E. Myers Jr., Westminster, Md. 21157</u>		25a. REC'D BY REGISTRAR <u>MAY 3 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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<div style="display: flex; justify-content: space-between;"> <div> <p>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>05013</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p> </div> <div> <p>05013</p> </div> </div>									
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> c. LENGTH OF STAY IN 1b <u>20 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>49 PENNA. AVE.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> d. STREET ADDRESS <u>49 PENNA. AVE.</u>				
3. NAME OF DECEASED (Type or print) <u>MAZIE PAULINE SHIPLEY</u>					4. DATE OF DEATH Month <u>APRIL</u> Day <u>12</u> Year <u>1967</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 8, 1890</u>		9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE & DOMESTIC WORKER</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM SUMMERS</u>					14. MOTHER'S MAIDEN NAME <u>MAMMIE PAULINE ?</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>213-28-1742</u>		17. INFORMANT <u>RALPH G. SHIPLEY</u> Address <u>TRAVELTOWN, MARYLAND</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis (acute)</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a.m. <u>—</u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>W. Lewis Perisher</u> M.O.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <u>4-12-67</u>	
EXAMINER'S NAME (Type) <u>W. Lewis Perisher</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) <u>Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/15/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>KRIDERS CEMETERY</u>		23d. LOCATION (City, town or county) <u>WESTMINSTER MD.</u>			
24. FUNERAL DIRECTOR <u>J. S. Myers Jr., Westminster, Md.</u>						25a. REC'D BY REGISTRAR <u>APR 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>	

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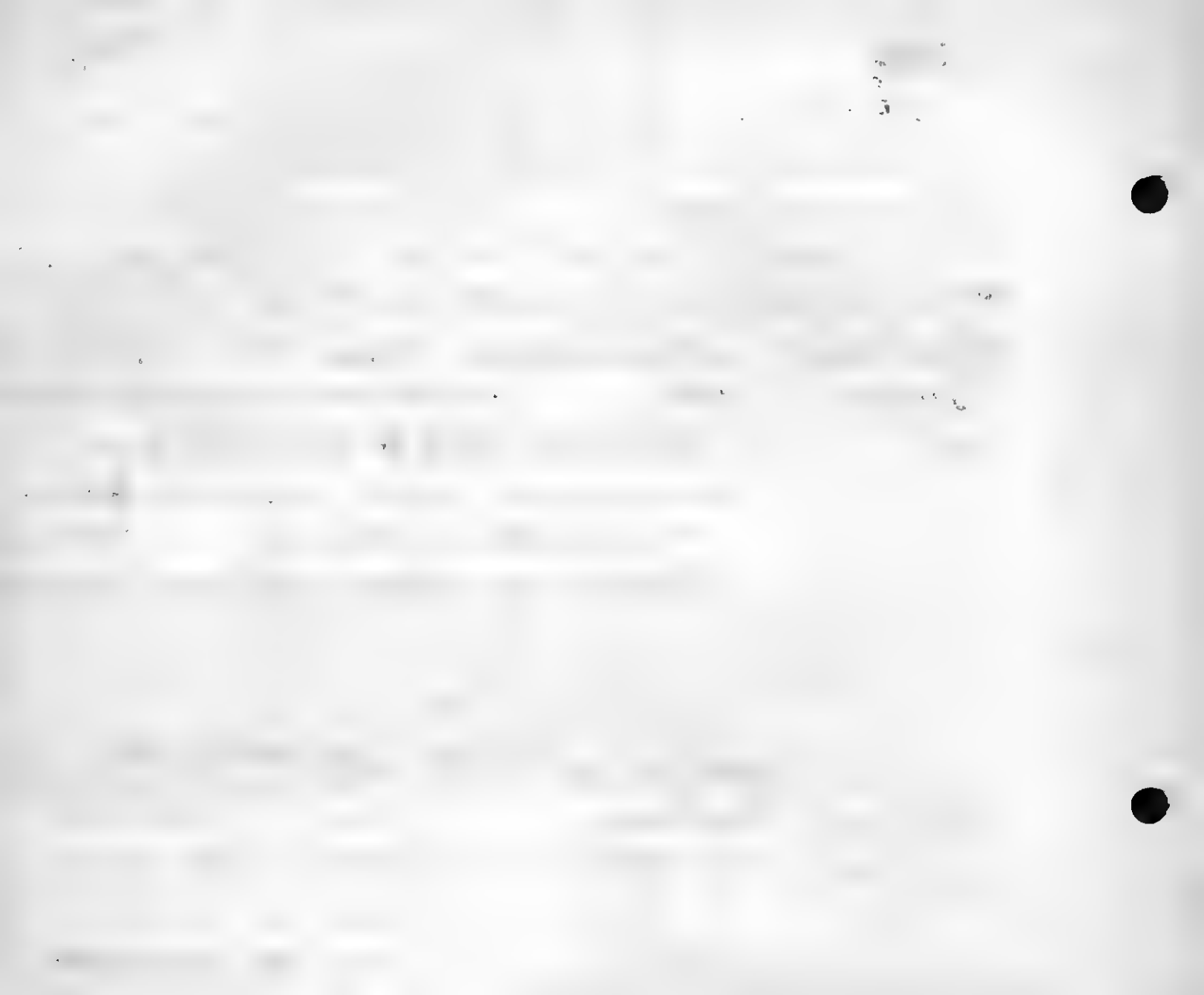
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05014 CERTIFICATE OF DEATH 05014											
1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER				c. LENGTH OF STAY IN 1b 42 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 51 UNION STREET						d. STREET ADDRESS 51 UNION STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WALTER Middle THOMAS Last SIMS						4. DATE OF DEATH Month APRIL Day 25 Year 1967					
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR 26 1979		9. AGE (in years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE				10b. KIND OF BUSINESS OR INDUSTRY GRADUATE SCHOOL		11. BIRTHPLACE (County & State, or foreign country) CARROLL, MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JAMES SIMS						14. MOTHER'S MAIDEN NAME ADMONIA HENRIETTA BENNETT					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 215-32-7718		17. INFORMANT WALTER ATLEE SIMS Address ROUTE #1 NEW WINDSOR, MD					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO (b) PULMONARY FIBROSIS DUE TO (c) PULVULAR HEART DISEASE										INTERVAL BETWEEN ONSET AND DEATH 10 MONTHS 10 YEARS 15 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from APRIL, 1966 to APRIL, 1967 , that (I) (we) last saw the deceased alive on APRIL 25, 1967 , and that death occurred at 6:58 AM , from the causes and on the date stated above.											
22a. SIGNATURE Daniel J Welliver						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-25-67			
22c. PHYSICIAN'S NAME (Type) DANIEL I WELLIVER						22d. ADDRESS BRIDGE RD WESTMINSTER MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 4/28/67		23c. NAME OF CEMETERY OR CREMATORY Edgewood Cemetery		23d. LOCATION (City, town or county) (State) Westminster Md.					
24. FUNERAL DIRECTOR J. S. Myers, Jr Westminster, Md						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge			
DATE APR 27 1967											

MEDICAL CERTIFICATION



05015

CERTIFICATE OF DEATH

05015

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY ---	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 yr, 5mo, 25da	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. STREET ADDRESS 3508 Ellamont Rd.	
3. NAME OF DECEASED (Type or print) MINNIE M. ST. PAUL SMITH		4. DATE OF DEATH Month April Day 25 Year 1967	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-28-72
9. AGE (in years last birthday) 91 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Uriah St. Paul		14. MOTHER'S MAIDEN NAME Katie E. Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Lincoln Dowd		Address 3508 Ellamont Rd. Balt. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADVANCED Generalized Arteriosclerotic Heart Disease DUE TO (b) Years DUE TO (c) 4.200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) Chronic brain syndrome assoc. w/cerebral arteriosclerosis w/psychotic			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) reaction.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-1-65 , 19__ to 4-25-67 , 19__, that (I) (we) last saw the deceased alive on 4-25-67 , 19__, and that death occurred at 2:15 PM , from causes and on the date stated above.			
22a. SIGNATURE Orlando C. Ramos		22b. DATE SIGNED 4-25-67	
22c. PHYSICIAN'S NAME (Type) Orlando C. Ramos		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/1/67	23c. NAME OF CEMETERY OR CREMATORY Poughkeepsie Rural Cem.	23d. LOCATION (City or Town) (County) (State) Poughkeepsie, N.Y.
24. FUNERAL DIRECTOR Herbert E. Lutter 3035 W. North Ave. Balt. Md		25a. REC'D BY REGISTRAR APR 26 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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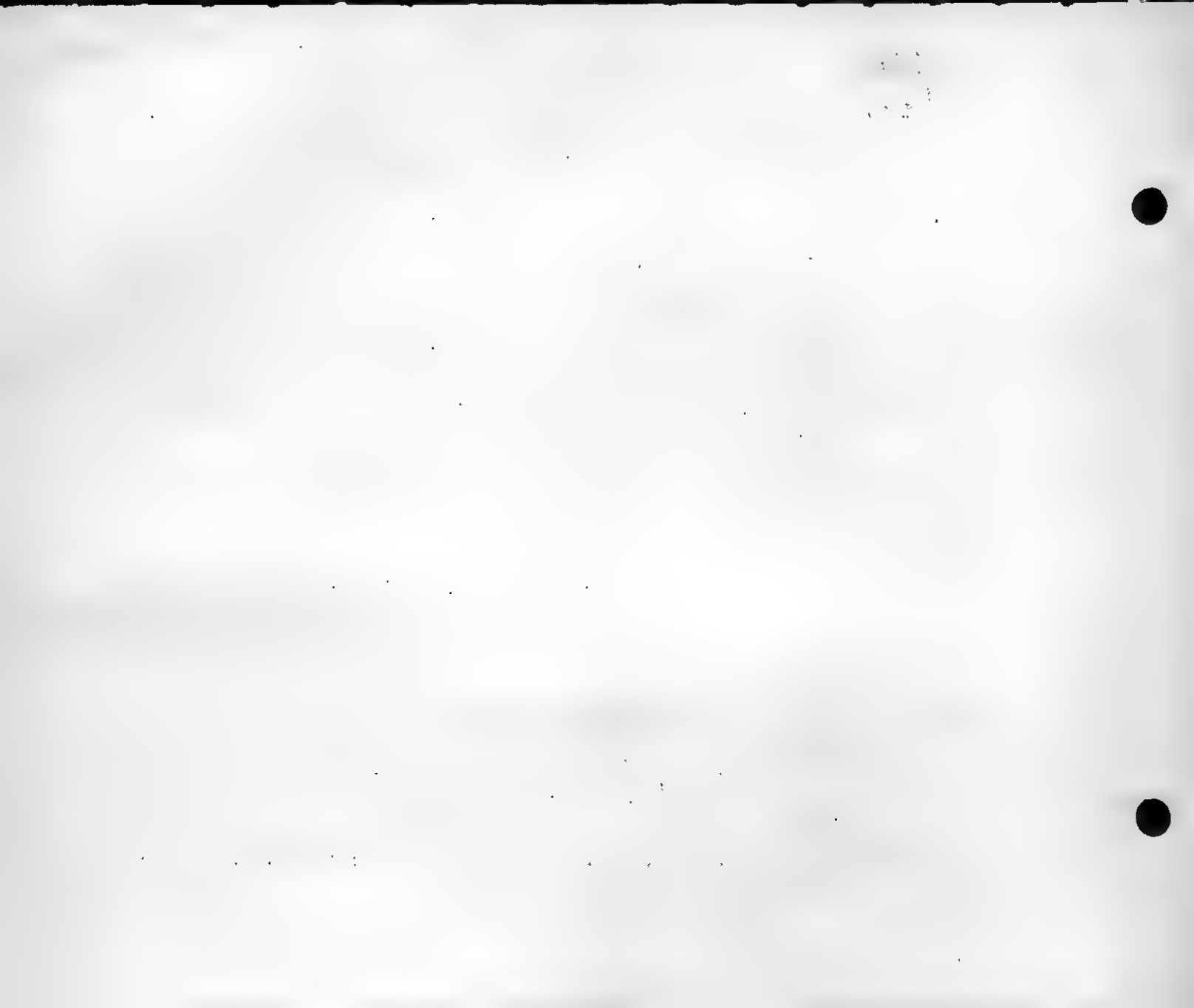
05016

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05016

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Marriottsville Road</u>				d. STREET ADDRESS <u>Marriottsville Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alma</u> Middle <u>Inez</u> Last <u>Stanton</u>				4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-20-1916</u>	9. AGE (In years last birthday) <u>50 yrs.</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Houseworker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Myers</u>				14. MOTHER'S MAIDEN NAME <u>Etta Thornton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u> </u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>4000</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac failure,</u> DUE TO (c) <u>Arteriosclerotic heart disease, Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4/17/67 through 4/23/67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 17, 1967</u> , to <u>April 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 23, 1967</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Howard E. Hall</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>April 25, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>				22d. ADDRESS <u>Sykesville, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-27-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prize Church Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Howard Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>				ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAY 1 1967</u>							



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05017

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05017

1 PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY N 1b 1yr. 9mos. 18dys.		2 USUAL RESIDENCE (Where deceased lived, f institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 2926 Harford Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) JESSE LEMOYNE TITUS		4 DATE OF DEATH APRIL 30 19 67		5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8 AGE (In years last birthday) 82		9 IF UNDER 1 YEAR Months 3 Days 30 Hours 19 Min 67		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam fitter		10b. KIND OF BUSINESS OR INDUSTRY Plumbing & Contracting		11 BIRTHPLACE (State or foreign country) Pennsylvania	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Samuel Titus		14 MOTHER'S MAIDEN NAME Ammie Paul		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 234-03-3595	
17 INFORMANT Records, Springfield State Hospital		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolism. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Phlebothrombosis of periprostatic venus plexus. (c) Fracture of left femur.		INTERVAL BETWEEN ONSET AND DEATH Minutes Days Week		PART II. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with circulatory disturbance other than cerebral arteriosclerosis, with neurotic reaction		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> Fell in bathroom & was unable to get up.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell in bathroom & was unable to get up.		20c. TIME OF INJURY Month, Day, Year 8:05 AM 4-21-67 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield State Hospital	
20f. (City or town) Sykesville		20g. (County) Carroll		20h. (State) Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 4-30-67	
ACTUAL SIGNATURE W. Glenn Speicher, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		23. LOCATION (City or town) (County) (State) Dorsey, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/3/67		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park Cem.		23d. LOCATION (City or town) (County) (State) Dorsey, Md.		24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.	
25a. REC'D BY REGISTRAR MAY 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S SIGNATURE Charles Judge		25d. REGISTRAR'S SIGNATURE Charles Judge		25e. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05018

CERTIFICATE OF DEATH

05018

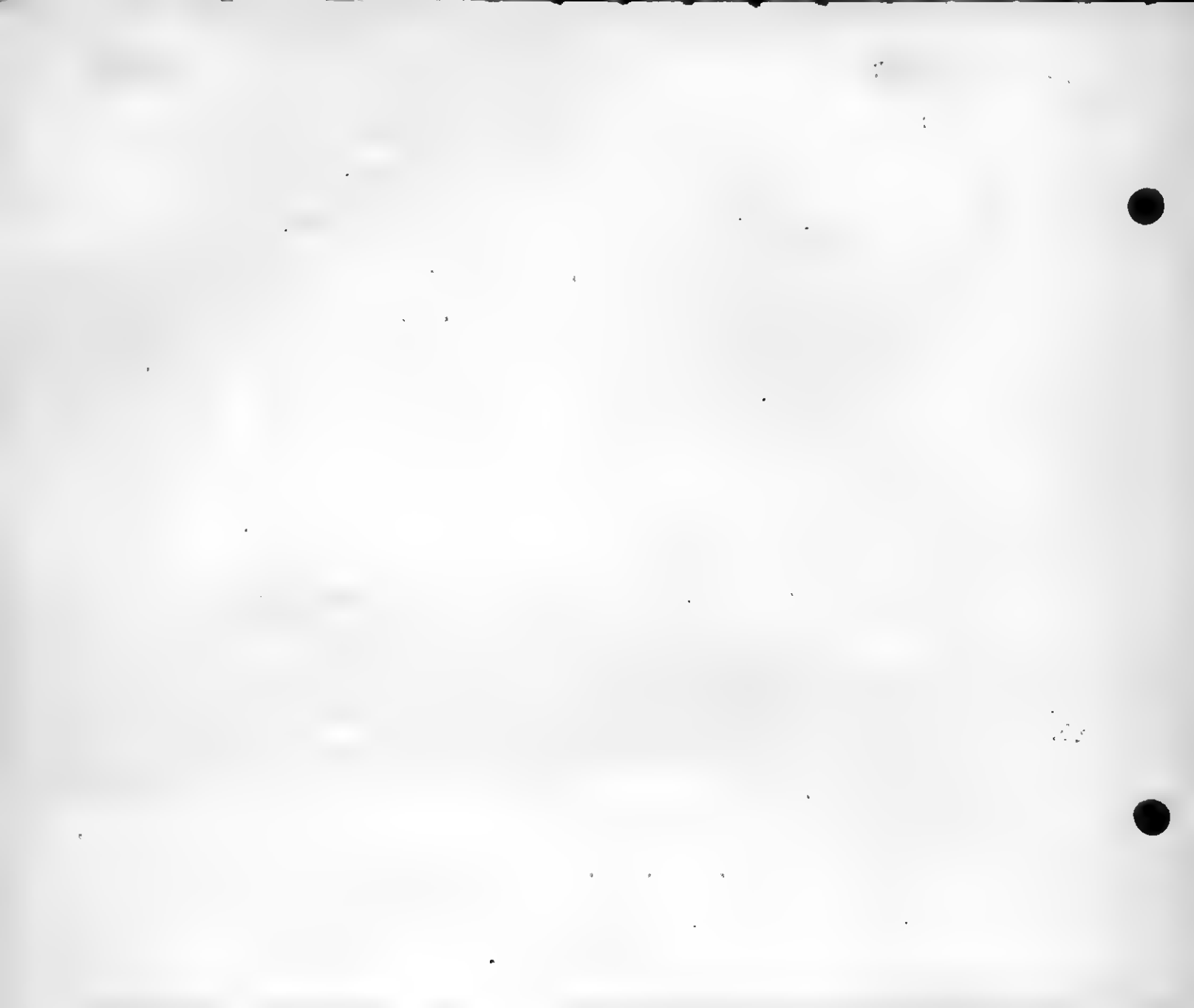
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester Md</u> c. LENGTH OF STAY IN 1b <u>15 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ingraw Nursing Home 1280 main fr.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Street, Md.</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>James</u> <u>melvin</u> <u>Townley</u>		4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1967</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 22, 1887</u>		9. AGE (In years last birthday) <u>79</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.		
IF UNDER 1 YEAR	IF UNDER 24 HRS.																		
Months Days	Hours Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (County & State, or foreign country) <u>Harford Co on Farm</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James Townley</u>				14. MOTHER'S MAIDEN NAME <u>Anna Rohe</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO <u>218-03 2268</u>		17. INFORMANT <u>Mrs. Loe Phipps (daughter)</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <table border="1" style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, </td> <td> (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO </td> </tr> <tr> <td colspan="2"></td> <td> (c) _____ </td> </tr> </table>												PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last,		(b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO			(c) _____	INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>1 yr</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last,		(b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO																	
		(c) _____																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>												20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18) _____							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____		(County) _____		(State) _____							
21. I certify that (I) (this hospital) attended the deceased from <u>3/30</u> <u>1967</u> , to <u>4/15</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>4/24</u> <u>1967</u> , and that death occurred at <u>8:30 AM</u> from the causes and on the date stated above.																			
22a. SIGNATURE <u>W.H. Foard</u>								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/15/67</u>									
22c. PHYSICIAN'S NAME (Type) <u>W.H. Foard</u> <u>M.D.</u>								22d. ADDRESS <u>Manchester, Md 21102</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>Apr. 18, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EMORY</u>				23d. LOCATION (City, town or county) <u>STREET, HARFORD Co., Md.</u>		(State) _____							
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins</u>														ADDRESS <u>DELTA, Pa.</u>		25a. REC'D BY REGISTRAR <u>APR 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05019 CERTIFICATE OF DEATH 05019

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Sykesville		c. LENGTH OF STAY IN ID 1 1/2 Years		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 3508 Ellen Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah		First		Middle E.		Last Wagner		4. DATE OF DEATH April 22, 1967		Month		Day		Year	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 8, 1970		9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Buxton		14. MOTHER'S MAIDEN NAME Kelly Triangle		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 018-54-347951	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 018-54-347951		17. INFORMANT Mr. Charles W. Wagner		Address Rt. 2 Lt. Airy, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, generalized; DUE TO (b) Arteriosclerotic heart disease, DUE TO (c) Cardiac failure, bronchial pneumonia.		INTERVAL BETWEEN ONSET AND DEATH 4/8/67 through 4/22/67		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 4/8/1967 to 4/22/1967, that (I) (we) last saw the deceased alive on 4/22/1967, and that death occurred at 11P M, from the causes and on the date stated above.		22a. SIGNATURE Howard E. Hall	
22c. PHYSICIAN'S NAME (Type) Howard E. Hall, M.D.		22d. ADDRESS Sykesville, Maryland		22b. DATE SIGNED April 23, 1967		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS		22g. DATE SIGNED		22h. SIGNATURE Charles Judge			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/25/1967		23c. NAME OF CEMETERY OR CREMATORY Marvin Chapel		23d. LOCATION (City, town or county) (State) Frederick Co., Md.		24. FUNERAL DIRECTOR C. L. Woltz		25a. REC'D BY REGISTRAR APR 26 1967		25b. REGISTRAR'S SIGNATURE			



05020

CERTIFICATE OF DEATH

05020

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY in lb <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>3803 West Saratoga St.</u>	
3. NAME OF DECEASED (Type or print) <u>MARTHA BERTHA GLENDOLA OTHELIA WALLS</u>		4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-12-96</u>
9. AGE (In years last birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>19</u> Hours <u>19</u> Min <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Sturdevant</u>		14. MOTHER'S MAIDEN NAME <u>Laura (maiden name unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records, Springfield State Hospital</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Far advanced cavitory pulmonary tuberculosis, active years</u> (c) <u>Far advanced cavitory pulmonary tuberculosis, active years</u>			
19. INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-17-67</u> , 19 <u>67</u> , to <u>4-19-67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-19-67</u> , 19 <u>67</u> , and that death occurred at <u>1:05 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Julian Radzykewycz, M.D.</u>		22b. DATE SIGNED <u>4-19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Julian Radzykewycz, M.D.</u>		22d. ADDRESS <u>Springfield State Hospital Sykesville, Maryland 21784</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Charles R. Law</u>		25a. REC'D BY REGISTRAR <u>APR 24 1967</u>	
ADDRESS <u>802 Madison Ave., Balto., Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

05021

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 21 Film 0389 5/25/67 kk

CERTIFICATE OF DEATH

05021

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Rural Westminster				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 7				d. STREET ADDRESS Route # 7			
3 NAME OF DECEASED (Type or print) First Susan Middle Grace Last Weishaar				4. DATE OF DEATH Month April Day 23 Year 1967			
5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH July 30, 1904	
9 AGE (In years last birthday) 62 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Charles Marquet			
14. MOTHER'S MAIDEN NAME Flora Lambert				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO 220-46-7859				17. INFORMANT Mr. Carroll Weishaar R # 7 Westminster, Md.			
18 CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer 1192 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 19, 1967 to April 24, 1967 , that (I) (we) last saw the deceased alive on April 19, 1967 , and that death occurred at 1:30 P.M. from causes and on the date stated above.							
22a. SIGNATURE E. Reese Wilkens M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-24-67	
22c. PHYSICIAN'S NAME (Type) E. Reese Wilkens				22d. ADDRESS 15 Kemper Ave., Westminster, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 26, 1967		23c. NAME OF CEMETERY OR CREMATORY Baust Cemetery		23d. LOCATION (City or Town) (County) (State) Tyrone, Carroll Co, Maryland	
24 FUNERAL DIRECTOR C.O. Fuss & Son				25a. REC'D BY REGISTRAR DATE APR 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05022

CERTIFICATE OF DEATH

05022

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 42yrs.23dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1924 S. Hanover St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CAROLINE (NMN) WENGERT		4. DATE OF DEATH Month APRIL Day 14 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-15-1879
9. AGE (In years last birthday) 87 yrs		10. IF UNDER 1 YEAR Months 11 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Germany	
11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Unk.	
13. FATHER'S NAME Heinrich Utz		14. MOTHER'S MAIDEN NAME Rosina (last name unk.)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-54-7428-T	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gangrene of left arm DUE TO (b) Marked generalized arteriosclerosis DUE TO (c) Schizophrenic reaction, paranoid type Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
19. INTERVAL BETWEEN ONSET AND DEATH Days Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-21-25 , 19 19 , to 4-14-67 , 19 19 , that (I) (we) last saw the deceased alive on 4-14-67 , 19 19 , and that death occurred at 1:10 P.M. from causes and on the date stated above.			
22a. SIGNATURE Dr. Antonius Glahn		22b. DATE SIGNED 4-14-67	
22c. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/17/67	23c. NAME OF CEMETERY OR CREMATORY Western Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Maryland
24. FUNERAL DIRECTOR Ambrise Fox 1328 Sulphur Sp. Rd		25a. REC'D BY REGISTRAR DATE APR 17 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05023						05023					
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Marbleton</u> c. LENGTH OF STAY IN TB <u>6 yrs 10 mos</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Impdw Nursing Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Linebrake, Ind</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Margaret D. West</u> First Middle Last						4. DATE OF DEATH <u>April 1 1967</u> Month Day Year					
5. SEX <u>Female</u>						6. COLOR OR RACE <u>White</u>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>May 2, 1905</u> 9. AGE (In years last birthday) <u>61</u> yrs					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Unemployed</u>					
11. BIRTH PLACE (County & State, or foreign country) <u>Lincoln, Maryland</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>William D. Wultz</u>						14. MOTHER'S MAIDEN NAME <u>Maryse Tracey</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>219-09-1535</u>					
17. INFORMANT <u>new Elder North, Thelma Fenderson, Ind</u>						Address					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Myocarditis</u> DUE TO <u>Coronary Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET DEATH					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)					
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year _____ 19____						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that (I) (this hospital) attended the deceased from <u>May 10, 1967</u> , to <u>Apr 1, 1967</u> , that (I) (we) last saw the deceased alive on <u>Apr 1, 1967</u> , and that death occurred at <u>5:34 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Joseph E. Bush MD</u>						22b. DATE SIGNED _____					
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>						22d. ADDRESS <u>HAMPSTEAD Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>4/4/67</u>						23b. DATE THEREOF <u>April 4, 1967</u>					
23c. NAME OF CEMETERY OR CREMATORY <u>Linebrake</u>						23d. LOCATION (City, town or county) <u>Linebrake Carroll Ind</u> (State) <u>Ind</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Heckle...</u>						25a. REC'D BY REGISTRAR <u>APR 4 1967</u>					
ADDRESS <u>45-55...</u>						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

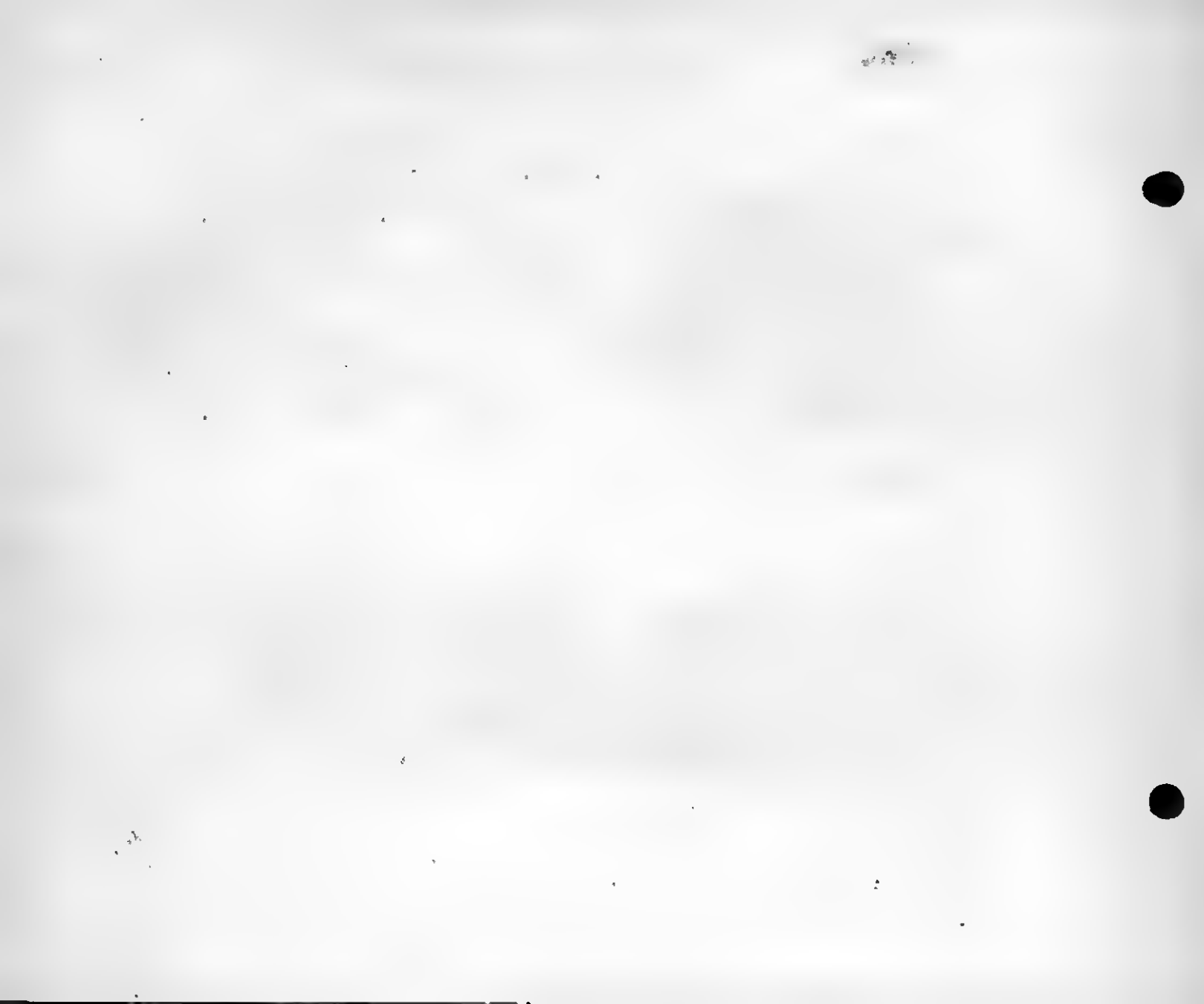
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

35024

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06526

1 PLACE OF DEATH a COUNTY Carroll b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c LENGTH OF STAY IN 1b 5 mos. 28 dys.		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First JACK Middle PROFITT Last WINTERS			4 DATE OF DEATH Month APRIL Day 29 Year 19 67		
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-22-17	9 AGE (In years last birthday) 50 yrs	IF UNDER 1 YEAR Months Days F UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber/Painter		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) North Carolina	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME William Winters			
14 MOTHER'S MAIDEN NAME Abbie (last name unk.)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1941-1945			
16 SOCIAL SECURITY NO. 556-18-3209		17. INFORMANT Address Records, Springfield State Hospital			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pyelonephritis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Days Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Alcoholism (addiction)					9 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>William Speidher</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) W. Glenn Speidher, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
23a BURIAL (CREMATION) REMOVAL (Specify)		23b. DATE THEREOF 5-4-67		23c. NAME OF CEMETERY OR CREMATORY V. of Md. Med School	
23d. LOCATION (City or town) (County) (State) Baltimore, Md.		23e. REC'D BY REGISTRAR DATE MAY 10 1967			
24 FUNERAL DIRECTOR Russell Funeral Home, Pikesville 8 Md.		25b REGISTRAR'S SIGNATURE <i>Charles J. J...</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural -- Sykesville		c. LENGTH OF STAY IN lb 5yr. 10mo 17		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital	
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Tessie Mary Wood		4. DATE OF DEATH Month April Day 20 Year 1967		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-3-01		9. AGE (In years last birthday) yrs. 66		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Clark		14. MOTHER'S MAIDEN NAME Mary Elizabeth Shilgon		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) --		16. SOCIAL SECURITY NO. none	
17. INFORMANT Springfield Records, Sykesville, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 493X IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) Pneumonic DUE TO (c) lost.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		21. I certify that (I) (this hospital) attended the deceased from June 3, 1961 to April 20, 1967 , that (I) (we) last saw the deceased alive on April 19, 1967 , and that death occurred at 1:15 A.M. from causes and on the date stated above.	
22a. SIGNATURE [Signature]		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Say Subior		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/22/67		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Philip Herwig Sons		25a. REC'D BY REGISTRAR APR 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05026						05025					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
Carroll			MARYLAND			Maryland			Carroll		
c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
12 days			Longview Nursing Home			Hagerstown			RD #4		
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
Caroline - Zimmerman						April 17 1967					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	
Female		White				NOV. 10, 1882		84 yrs.		Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				12. KIND OF BUSINESS OR INDUSTRY				13. BIRTHPLACE (County & State, or foreign country)			
Home maker				Home				Switzerland			
14. FATHER'S NAME				15. MOTHER'S MARRIED NAME				16. CITIZEN OF WHAT COUNTRY?			
John Hever				Ruth Hever				U.S.A.			
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				18. SOCIAL SECURITY NO.				19. INFORMANT			
no				218-02-4745				Marie A. Summers, 310 #4			
1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											
4201 DUE TO											
Crown occlusion											
Chronic myocarditis											
Autoschistis Cerebri Vasculi											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)											
20c. TIME OF INJURY											
Hour a.m. p.m. 19											
20d. INJURY OCCURRED											
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Apr 5, 1967, to Apr 17, 1967, that (I) (we) last saw the deceased alive on Apr 17, 1967, and that death occurred at 11 A.M. from the causes and on the date stated above.											
22a. SIGNATURE											
Joseph E. Bush M.D.											
22b. DATE SIGNED											
4/17/67											
22c. PHYSICIAN'S NAME (Type)											
Joseph E. Bush M.D.											
22d. ADDRESS											
7 Hampstead Maryland											
23a. BURIAL, CREMATION, REMOVAL TO SPECIAL											
Burial											
23b. DATE THEREOF											
4/20/67											
23c. NAME OF CEMETERY OR CREMATORY											
Lester Cemetery											
23d. LOCATION (City, town or county) (State)											
Westminster MD #4 Md.											
24. FUNERAL DIRECTOR'S SIGNATURE											
J.E. Meyers Jr.											
25a. REC'D BY REGISTRAR											
APR 20 1967											
25b. REGISTRAR'S SIGNATURE											
Charles Judge											

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RECEIVED
JAN 10 1902
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

Handwritten notes and signatures, including "C. J. ...", "J. ...", and "C. J. ...".

Handwritten notes and signatures, including "C. J. ...", "J. ...", and "C. J. ...".